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SUPPORTING TRANSITIONALLY HOMELESS WOMEN IN RURAL REGIONS: THE NEED FOR TRAUMA-INFORMED CASE MANAGEMENT

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Abstract
Homeless women and female-headed homeless families represent 80% of the transitionally homeless population. Homelessness in rural and suburban regions has been increasing, and the use of homeless programs in rural and suburban areas has grown by 57% since 2007. Homeless women and their children come to shelters in vulnerable states with histories of complex and chronic trauma; they need strategic services delivered in a way that is sensitive and responsive to their experiences. Social-service providers who work with transitionally homeless women in rural and suburban regions have limited resources and growing demand for their services. The curriculum described is designed to be responsive to the nuanced needs of homeless women and to their case managers, who must serve clients with increasingly complex and harsh experiences. The curriculum details (a) how stress response affects adaptive coping and shapes behavior in stressful situations; (b) how managers can optimize resilience, developing a care plan by monitoring their own responses; and (c) how to assess, engage, and intervene using principles of trauma-informed care. The case management sessions focus on key areas of need specific to this population. These include (a) health and human services, (b) education and employment, (c) parenting, (d) interpersonal violence, (e) and emotional regulation. The aim of this curriculum is to ensure that upon contact with a shelter system or any transitional housing, women have meaningful interactions with their case managers that help them feel safe, grow, and connect with the community and the resources they need.

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ABSTRACT

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Homeless women and female-headed homeless families represent 80% of the transitionally homeless population. Homelessness in rural and suburban regions has been increasing, and the use of homeless programs in rural and suburban areas has grown by 57% since 2007. Homeless women and their children come to shelters in vulnerable states with histories of complex and chronic trauma; they need strategic services delivered in a way that is sensitive and responsive to their experiences. Social-service providers who work with transitionally homeless women in rural and suburban regions have limited resources and growing demand for their services. The curriculum described is designed to be responsive to the nuanced needs of homeless women and to their case managers, who must serve clients with increasingly complex and harsh experiences. The curriculum details (a) how stress response affects adaptive coping and shapes behavior in stressful situations; (b) how managers can optimize resilience, developing a care plan by monitoring their own responses; and (c) how to assess, engage, and intervene using principles of trauma-informed care. The case management sessions focus on key areas of need specific to this population. These include (a) health and human services, (b) education and employment, (c) parenting, (d) interpersonal violence, (e) and emotional regulation. The aim of this curriculum is to ensure that upon contact with a shelter system or any transitional housing, women have meaningful interactions with their case managers that help them feel safe, grow, and connect with the community and the resources they need.

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Chapter 1: Problem

Introduction

Homeless individuals face tremendous physical, emotional, and psychological challenges and are in active states of crisis. They often have histories that include traumatic and adverse life experiences; the very state of homelessness can be traumatic. An estimated 1.5 million people use shelter services annually, and up to 44 million Americans report having being homeless at one point in their lives (AHAR, 2010; Kuhn, Culhane, 1998; Link, Bruce, Susser, Stueve, Phelan, Moore, & Struening, 1994). Although rates of homelessness have been declining in the United States overall, the rates of homelessness among families, specifically in rural and suburban areas, have been increasing (AHAR, 2010).

Homeless families comprise 37% of the total homeless population, but are disproportionally represented by female-headed families, with 77% of homeless families comprising a mother with two dependent children (AHAR, 2010). Moreover, homeless individuals and families have higher rates of victimization, mental health disorders, substance abuse issues, and often have insufficient economic resources; these conditions are even more pronounced when the homeless individual is female (Bassuk, Weinreb, Buckner, Browne, Salomaon, Bassuk, 1996; Courtois, & Gold, 2009; First, Rife, & Toomey, 1994; Hopper, Bassuk, & Olivet, 2010; Robertson, 1991;Tucker, D'Amico, Wenzel, Golinelli, Ellott, & Williamson, 2005). Most attention, research and implementation dollars for homeless services have been given to chronically homeless population, defined as being continuously homeless for at least one year or had at least four episodes of homelessness in the past 3 years, although they only

comprise of 10% of total homeless population (Chulhane, Dejawski, Edmund, & Ibanez, 1994; Rickards et al., 2010; Shern, Surles, & Waizer, 1989).

Studies of homelessness indicate that supportive services beyond the provision of shelter services must be included in comprehensive responsive services to homeless populations (Hopper, Bassuk, & Olivet, 2010; Hamilton, Poza, & Washington, 2011). After entering into a shelter or transitional setting, a sustained condition of emotional and physical vulnerability can disrupt or sabotage attempts to be independent. Shelter services provide supportive and transitional services, but often do not have the tools or resources to directly deal with recent or past trauma (Nelson, Aubry, & Lafrance, 2007; Rog, 2004). In fact, some shelter conditions may unwittingly create environments that can retraumatize or retrigger their clients. Shelters use case management as the primary mode for providing stabilization and supportive services, but roles and services are not well operationlized and there are no universally adopted treatment protocols or tools (Heslin, Anderson, Gelberg,2003; Weinreb & Rossi, 1995) . Case management models such as assertive community based therapy or critical-time intervention have empirical support for helping with homeless populations (Latimar, 1999; Susser, Valenica, Conover, Felix, Tsai; Test & Stein, 1976) . However, it is important to note that these models have typically been applied to chronically and persistently homeless families and are not designed to directly address traumatic experiences.

Service providers have expressed feeling overwhelmed by the intensity and volume of the problems their homeless clients face, and have expressed the need for tools to help address clients' trauma (Bussey, 2008; Cunningham, 2003; Saakvtine, 2002). This need is even more pronounced in rural areas in which there is a single shelter provider for all populations and where fewer resources require one-size fits all service models (GAO, 2010). Social workers have

historically worked in case management roles that rely on the person-in-environment and a systems orientation that makes them a strong fit for frontline work such as shelter or community based work (Mueser, Bond, Drake & Resnick, 1998). Many have also worked extensively with homeless populations and would benefit from a model that specifically addresses the traumatic incidents in the lives of the clients they serve.

Similar to homeless studies, trauma studies gained considerable momentum in the 1980s as subjugated narratives and invisible and marginalized experiences and groups gained visibility (Herman, 1992). Homeless populations, and specifically homeless women and children, became visible as they began appearing in the streets and sleeping in areas not meant for human habitation (Rossi, 1990). Simultaneously, trauma studies began gaining attention as prominent researchers and grass roots movements, often in conjunction with feminist movements, began demanding that society no longer turn a blind eye to acts of violence against women and children (Abaigi & Wilson, 2005; Balaev, 2008; Cartuth, 1996; Herman, 1997; Savage, Dodd, & Bonavatoa, 2007). This era provided a base of scholarship on the issue that included investigations into the effect of chronic stress some resulting from adverse life experience, and the neurobiological consequences of emotional dysregulation on neurobiological development from traumatic experiences; these early works provided empirical support for today's clinical and qualitative observations (Felitti, Vincent, Anda, Robert, Nordenberg, Williamson, David, Spitz, Alison, & Edwards, 1998; Pynoos, Steinberg, Ornitz & Goenian, 1997; Schore, J. & Schore, A., 2008)

As a result of the research and attention gained during the 1980s, the two areas flourished since then, resulting in advances in knowledge and services for homelessness and traumatized populations. Today, there are even trauma informed tool-kits for homeless populations and for

homeless women and children (Guarino, Soares, Konnath, Clervil & Bassuk, 2009; Prescott, Soares, Konnath & Bassuk, 2008). Though these advances mark an improvement in the field, they tend to be descriptive and aim at helping the system become trauma sensitive; they do not discuss how to deliver key services that speak to the specific needs of transitionally homeless women. Current models for trauma specific interventions are too often relegated to additional costly models for already financially strained systems (Abramovitz & Bloom, 2003; Cohen & Mannarino, 2008; Ko, Ford, Kassam-Adams, Berkowiz, Wilson, Wong, & Lane, 2008). Further, they do not specifically address how to help homeless women or their case managers to negotiate the specific needs of this population through the application of trauma informed principles. This challenge is further exacerbated in rural or suburban areas that often have limited resources, often in the form of a single transitional shelter to provide services for the entire population. This setting would directly benefit from trauma specific case management services that address the typical needs of shelter residents, and such tools would be valuable in supporting and stabilizing homeless populations.

Because there is limited data on the needs of transitionally homeless women, this author was a co-investigator in a community based participatory research (CBPR) with a transitional shelter in a rural area and found, consistent with other researchers, that single homeless women and women with children expressed the need for help in the areas of health and human services, education, and parenting. They expressed feeling overwhelmed by external and internal barriers and needed assistance in strengthening their internal and external supports so they can become self-sufficient. A review of the literature, as well as personal experience in working with homeless women and families, also revealed substance abuse and domestic violence as areas that

commonly co-present in these settings and specific models must be employed to address the complex needs that accompany such circumstances.

Building on the knowledge gained from the CBPR, the aim of this curriculum is to review homeless and trauma studies, including a discussion of existing treatment models in homeless services and trauma treatment, to develop a treatment framework for trauma informed case management. To accomplish this, a comprehensive and culturally competent assessment must be developed to account for ethnic and cultural identities and experiences of the women that present for services. Such an assessment must also consider both content and process of service delivery, and must aim for process oriented principles such as motivational interviewing (Miller & Rollnick, 2002) and Prochaska's stages of change (Proschaska & Norcross, 2001) to guide the treatment process.

The model must also include monitoring the environment in which care is being given, most often the shelter, and also the care-giver's well being. The proposed curriculum will be composed of treatment modules, each of which has a specific goal. The treatment modules include:

- Accessing health and human services,
- Education,
- Parenting,
- Employment, and
- Emotional regulation and attunement.

The curriculum will also include self-anchoring assessments that measure the subjective goals of the client, as well as assessment of the relationship between the case-manager and client. Since the case-manger is the primary support system, it is vital that the clients feel safe and supported, and feel that they are receiving competent services. The assessments will also be

process-oriented so that areas of need are identified on an ongoing basis, and there will be tools in place for emergencies or crisis. The curriculum will also include recommendations for services that target children as well as trauma-informed frameworks for understanding dynamics of substance abuse and interpersonal violence.

Homelessness

Resurgence of homelessness.

In the late 1970s homelessness gained considerable public attention and empathy because homeless populations became more visible and included women and children (Rossi, 1990). They are described as the visibly marginalized because of the obvious lack of residence (Lee, Tyler, & Wright, 2010) but many also live in precarious or states of emergency housing that may not be as observable but remain vulnerable (Culhane & Metraux, 2008). Methodological and discipline differences have varied the in their definition and prevalence of homelessness but have become less contentious compared to past attempts at enumeration and operational definitions (Israel, Toro, & Ouellette, 2010; Lee, Tyler, & Wright, 2010; Quigley & Raphael, 2001 Shinn, 2007; & Rossi, 1990)

Rossi (1990), a prominent sociologist focused on the study of homelessness summarized the emergence of homelessness in the 1980's, and the ensuing research and supportive services that followed. Before the 1980's the last surge of homeless population was related to the great depression and consisted of transient young men that did not want to be a burden to their families. World War II helped the economy by absorbing the unemployed men into the military and by giving the economy a boost. Homelessness was restricted to skid rows that consisted of cheap hotels, bars, restaurants, and employment agencies close to railroads. It was predominately older

white men that were isolated from their families living on pensions or had disabilities (Bogue, 1963). But when single room hotels and flop houses were demolished and replaced with downtown building and luxury high rises, skid rows moved to specific parts of town. The displacement of skid rows did not eradicate homelessness.

Instead new type of homelessness population began to appear, visibly sleeping in areas not meant for human habitation and included women and children. They began appearing at public welfare institutions asking for assistance, and social service agencies began responding to this need. Studies reviewed by U.S. General Accounting Office (GAO) in 1985 and 1988 indicate an annual growth rate of homelessness between 10- 38%. Federal and local agencies initially responded by establishing emergency shelters. Later, the emphasis shifted to housing and service needs and, in1987, federal funding for transitional and supportive housing was established with Stewart B. McKinney Homeless Assistance Act. HUD was tasked with carrying out the mandate. In 1994, HUD created an integrated Continuum of Care (CoC) and named transitional housing as a necessary component to a comprehensive response to homelessness (HUD's 1995 report to Congress). It was also developed as a response to the diverse needs of the homelessness population and, specifically, to respond to the needs of homeless women, children and youth.

Definition and prevalence of homelessness. Contemporary definitions of homelessness define homelessness in more fluid terms and describe it in many forms including: literal homelessness, housing and economic hardship, being precariously housed and at an eminent risk of homeless, not having proper night time residence, a severe condition of housing deprivation and extreme condition of poverty, being doubled up or living in sub-standard housing including hotels (Culhane & Metraux, 2008; Lee, Tyler, & Wright, 2010; & Rossi, 1990). Causes or being

vulnerable of becoming homeless have been described in terms of individual vulnerabilities, an influence of socio-structural causes, or as an interaction of the two forces. Individual vulnerabilities include personal characteristics of at-risk populations, situational crisis, and personal risk factors. Macro or structural causes include housing shortages, economic conditions, unemployment, policy shifts in welfare, and housing and mental health. Individual and structural issues impact one another as structural hardships exasperate personal vulnerabilities and magnify consequences.

In their structural analysis of homelessness, Elliott & Krivo (1991) discuss the rising cost of housing prices coupled with poor economic conditions that placed a great strain on those who were already economically disadvantaged. In the 1980's median monthly rent rates rose by 192% while incomes only rose by 97% during the same time. As a result the rent to income ratio dramatically increased and renters began paying over half of their income towards rent (Gilderbloom, 1989). There was also lack of affordable low-income housing and wait lists for public housing began rapidly growing.

Deinstitutionalization or the crack cocaine epidemic are often cited as popular explanations for the rise in homeless population, but Quigley and Raphael (2001) reject this explanation and instead posit that other institutional settings absorbed deinstitutionalized people. This is evidenced by increase in the number of people in jails, prison, and inpatient facilities. Instead they state that changes in housing market coupled with increasing income inequality better account for rates of homelessness. They also conclude that people in lower end of the income distribution are further marginalized by market polices and need responsive policies and services to help overcome inherent injustices.

With regards to demographic and prevalence rate of homelessness, in 1990's government census attempted to measure homelessness by point-in time count only (did not include total use of shelter services) and drew large criticism for gross under- reporting by social scientists (Rossi, 1990). Period prevalence studies done by Culhane and associates (1994) counted the number of homeless people at a given time in their lives, measured by shelter use, that resulted in higher numbers. The study revealed that 3% of people in Philadelphia and New York used shelter system at one point in their life. This prompted similar enumeration and national data collection by the federal government, and it is now estimated that 1.5 homeless Americans are currently homeless (AHAR 2010). This, however, only relates to shelter users. A broader period-prevalence study (Link, Susser, Stueve, Phelan, Moore, & Struening, 1995) or lifetime prevalence study (Toro, Rabideau, Bellavia, Daeschler, Wall, & Thomas, 1997) that used probability sampling, indicated a range from 6-14% of respondents reported being homeless at one point in their life, meaning up to 37 million people.

Considerable efforts by HUD to have multiple sources of data to capture rates of homelessness and services provided to homeless populations have been acknowledged. The 2010 Annual Homeless Assessment Report to Congress (AHAR) details the most current national breakdown of homeless population measured by shelter use and point-in-time counts. It breaks down the population by frequency of shelter and categorizes use as transitional, episodic, and chronically homeless. Transitional homelessness is defined as one short-term stay, episodic homelessness is shuttling in and out of homeless services, and chronic homelessness is being continuously homeless for at least one year or has had at least four episodes of homelessness in the past 3 years. It is in these breakdowns that we see the increased vulnerabilities of women and in particular women headed families categorized as transitionally homeless.

Transitionally homeless women and families. The 2010 AHAR report revealed the ethnic demographic breakdown of the total homelessness population as follows: 41% white, 37% black, 9.7 % Hispanic, and 12% as other. These numbers indicate a radical shift from the skid-row homeless population that comprised largely of older white men and reveals a disproportionate number of minority populations as being currently homeless. People who are experiencing transitional homelessness, (i.e., one short-term stay in shelter or transitional setting), are 80% of shelter users with 62% males, 38% female, and 21% under the age of 18. However, it is the chronically homeless, 11% of total homeless population that use over 50% of shelter services and receives the most attention (Latimer, 1999; Morse, 1999; Rosenheck, 2000; & Toro, et al. 1997) .

Unfortunately, 77% of homeless families are typically a mother and two children and comprise 37% of the total homeless population (AHAR 2010). Although homeless rates are decreasing for the general population, family homelessness has been increasing and female-headed families are staying longer in transitional shelters. Weinreb and Rossi (1995) reviewed national shelter services provided to families and noted that family shelters accounted for 39% of all shelters and majority of homeless families were a single woman with a dependent child. However, the shelters control who can be admitted an in turn selectively shape the demographic and social characteristics of homeless families. This means that families with larger number of women or with more chronic needs or vulnerabilities may not be admitted to shelters. Again, those with more disordered functioning and backgrounds are prohibited from receiving needed services and are at risk for more victimization that could even lead to death.

To better understand the growing population of homeless families, Bassuk and Rosenbeg (1988) compared homeless female-headed families to housed female-headed families. They

discovered that homeless mothers were more abused as children, had higher rates of drug and alcohol use, were more likely to be victims of violence, and had fewer social supports. Later Bassuk and associates (1996) compared characteristics of homeless women to low-income housed mothers across economic, psychosocial and physical health domains. Similar to previous findings, homeless mothers reported higher instances physical and sexual assault over a life span (91% vs. 80%) as well as more residential instability. Lastly Bassuk (1997) and associates attempted to indentify risk and protective factors for homeless families. Their study revealed that foster care placement of mother, family history of violence, interpersonal conflict, recent eviction, and having minority status (which is not surprising since 58% of homeless population is comprised of minorities) were risk factors that contribute to family homelessness.

With regards to health demographics, the 2010 AHAR data indicated that of the total sheltered homeless population in their point-in time count, 26% have serious mental illness, 34.7% have substance abuse, and 12.3% are victims of violence. Research on homeless women shows that homeless women with children consume or use alcohol and drugs less than single homeless women (16% compared with 6%) but have higher rates of use compared to poor women with children (Nemiroff, Aubrey, & Klodaswky, 2011 & Robertson, 1991). In Weinreb and Rossi (1995) assessment of homeless families, they discovered 49-51% mothers struggled with drug and alcohol abuse and 43% had mental health issues.

Regarding psychological distress or mental health, as mentioned homeless mothers and women have histories that include extensive childhood abuse, neglect, disrupted attachment, and histories of childhood homelessness (Hopper, Bassuk, & Olivet, 2010). A study evaluating the trauma-informed services for women with co-occurring disorder and trauma exposure revealed that 70.4% of women have been homeless at some point in their lives (Morrissey, Jackson &

Ellis, 2005). They also have higher levels of psychological distress and mental health problems compared to men (Roll, Toro, & Ortola, 1999).

Moreover, 92% of the mothers report having experienced severe physical or sexual abuse over a lifetime with two-thirds having histories of domestic violence and a reported three times the rate of post-traumatic stress disorder. These number are much higher compared to 2010 AHAR general population demographic data. Mental health services and substance were cited as the most prevalent intervention need across sites (Rog, Holupka, & McCombs-Thornton, 1995). This translates into increased dependence on drugs and alcohol at the rate of 41%. Indicating a need for responsive interventions for homeless women and children, these alarming statistics reveal the extent to which they are marginalized and at-risk.

Lastly, children that are homeless are exposed to traumatic and adverse life experiences that affect their overall development. As mentioned, women, specifically mothers, comprise the largest percentage of homeless families, and the 2010 AHAR report reveals 200,000 children are homeless with 42% of them being under the age of six-years old. Medical records of homeless children revealed that they have multiple health problems (most notably respiratory), poor nutrition, developmental delays, anxiety and depression, behavioral problems, and educational under achievement (Rafferty & Shinn, 1991). Homeless Resource Center, a part of Substance Abuse and Mental Health Services Administration (2010), also reported in their research that among homeless children: 97% have multiple moves, 22% are separated from families (most shelters segregate by gender), and 25% witness violence. These existing vulnerabilities are compounded by their mother's own traumatic history and current drug and alcohol abuse. These demographics highlight the supportive services needed to address the needs of this population.

Rural homelessness. As mentioned homelessness in rural and suburban areas have been

increasing and the 2010 AHAR computation reveals since 2007 the use of shelters in these regions has increased by 17% and even more astonishing, the use of homeless programs has increased by 57%. In 2010, 64% of shelters users were reported to live in urban areas while 36% lived in suburban and rural areas. Although the prevalence of homeless is higher in urban areas, the growth rate in rural and suburban areas, and the concentration of homeless women and families in the rural areas is alarming. A concrete definition of what constitutes as rural is useful to clarify how policy is instituted and how needs for services are determined. However, perhaps as expected, there is not a universal definition of rural and this further complicates enumeration and service delivery.

The definition of rural and rates of rural homelessness vary among federal programs such as education, labor, agriculture, and health and human services and make collecting data on homeless or those receiving homeless services difficult (GAO, 2010). For example department of education definition of homelessness for children and youth includes individuals living in substandard housing condition, whereas HUD's definition of homelessness does not include these criteria . HUD's statuary definition of homeless is more restrictive compared to other programs (McKinney-Vento Homeless Assistance Act 2002). Health and Human Services Department defines doubled up condition as well living in substandard housing as being homeless, a broader and perhaps more comprehensive definition. The agencies also use differing reporting mechanisms to collect data, although they are all encouraged, but not mandated, to report their findings to HUD. They remain differentiate silos that may be under-serving or duplicating services to homeless people in rural areas. This a notable problem because information relating to rural homeless populations tend to be sparse already and in some instances, more rare, service providers maybe providing services but not necessarily

documenting or reporting the rates of services to homeless population in their outcome measures (Mosley & Miller, 2004). This helps contribute to under-reporting that exists.

Currently the United States Census Bureau uses the Office of Management and Budget (2010) to help geographically demark what is urban and rural. It delineates what constitutes as urban areas and defines rural as territories that are outside of urbanized areas and/or clusters. The Office of Management and Budget uses county geographies to define metropolitan and non-metropolitan areas. An area with population of 50,000 or more that has surrounding counties with high commuting activities is defined as metropolitan while a micropolitan is defined as an area that contains urban core of at least 10,000 but less than 50,000. In a similar fashion, the Census Bureau classifies urban in two manners: an urbanized areas or an urban cluster. An urban area is defined as region with 50, 000 or more people (similar to a metropolitan area) while an urban cluster as ranging between 2500 and 50,00 (similar to micropolitan area). And by exclusion, rural areas are defined as all populations and territories that are not included in the urban areas or clusters. In similar fashion non-core counties defined by the Office of Management and Budget are considered to be counties that are not classified as metropolitan or micropolitan. In general micropolitan and non-core counties are used to define what constitutes as rural regions. The 2010 rural and urban census classification reveals that 81% of the nation is classified as urban and 19% is rural.

On the other hand HUD (2010) uses a continuum of care (CoC) system that uses competitive and formula based programs to fund supportive services that address homelessness in identified comminutes. CoCs are key stakeholders in geographical area HUD utilizes them to award and administer funds. A CoC can vary from being a single entity in a large city, or often for rural areas, organize into regional sections or by process of elimination be the areas of the state that

are not being covered by other continuums. The counties that represent the CoC can be classified as urban, mostly urban, rural, mostly rural, or rural-mix. There are a total of 457 CoCs recognized by HUD and a region is considered rural if it is a single rural county (as defined by the Census Bureau) and if most of the general population resides in rural part of the CoC. It is considered mostly rural if 80% or more of the population resides in the rural part. Similarly, mostly urban is when 80 % or more of the population resides in counties that are urban. Using CoC classification, the Homeless Research Institute (2006) indicates that 14% of homeless population is rural, 22% as rural and mostly rural, and 34% as ranging from rural to urban rural mix. Again, although most homeless population falls into urban classification, two of the highest rates of homelessness in all the CoC belong to rural CoCs. Government Accountability Office (2010) tabulated that in 2009 the federal government allotted $2.85 billion on programs targeted towards needs of homeless. HUD received 62% of funding and spent $130 million on rural programs (15% of its funds). Given the growing needs of rural and suburban populations, there is a marked need to increase funding and services to the areas.

Lastly, the United States Department of Agriculture also provides supportive services and rural housing program to rural homeless populations . It also uses population thresholds to define rural as population as opposed to the metro-statistical areas definition used by the Office of Management and Budget. The rural population parameter is outlined between 10,000 and 25,000 people and the area must be rural in character as defined by field staff. The USDA handbook contains implementation guidance to help staff determine eligible areas by helping define what constitutes as open country, population, contagious areas and rural character. However, in their systematic assessment of rural housing services, the Government Accounting Office (2004) was critical of the USDA for its poor articulation of what constitutes as rural in character. Because

individual field officers determine what regions are eligible to receive services an ambiguous definition of what is rural character creates inequality in how eligibility and services are determined and disseminated. Subjective interpretation leads similar rural areas to receive different designation and causes inconsistency in tabulation of rurality.

Despite enumeration problems, the federal government has historically acknowledged the increased rates of poverty in rural areas compared to urban and has been providing housing assistance to rural areas since the 1930's. The United States Department of Agriculture (USDA) was tasked developing rural housing and its Rural Housing Service (RHS) administered supporting programs and lending programs. Specifically, the Housing Act of 1949 authorized lending programs for individuals with land capable of producing at least $400 worth of products. Later, additional amendments expanded eligibility to include people living in rural areas, defining rural areas as areas with population up to 5500 and being rural in character. The population threshold was increased to 25,000 and RHS determines which areas were defined as rural and eligible for its programs as explained above. Residents living in rural areas with low to moderate incomes could apply for loans and grants or for those whose incomes were too low to pay the subsidized rates, there is rental assistance. Assistance is also provided for housing preservation for rehabilitation of homes and as well as funding or sponsorship of programs for organizations to help repair homes. Despite these efforts there continues to be large needs and continued barriers for service delivery, which will be further explored.

As mentioned there are increased rates of poverty and unemployment in rural areas and homeless populations tend to be less visible in rural regions because of limited shelters and social service supports. Rural areas have economic struggles that include farm foreclosures and agriculture dependent areas have lost local earning and tax revenues. Increase in rural

homelessness has exasperated existing systems and social workers struggle to provide services because of the high rates of unemployment, insufficient emergency funding stream, poor child care and transportation services, lack of low-income housing, and the large geographical areas they are expected to cover with minimal support. Mosley and Miller (2004) in their research brief for The Rural Policy and Research Institute discuss causes and consequences of poverty in rural areas. They indicate persistent poverty as an overwhelming rural issue and found that female-headed families are the most vulnerable, compared to their urban counter parts. They report a significant lag in income and education levels, which are often protective factors. Moreover, underemployment and informal work is widespread in rural areas and transitioning into higher earning jobs or being able to be upwardly mobile is severely restricted.

Acknowledging these challenges and yet still needing empirical data on rural homelessness First, Rife and Toomey (1994) conducted one of the largest studies on rural homelessness that included 21 randomly selected rural counties in mid-western united states with a sample of 919 adults that included 274 families and 480 children. Using population density measures they surveyed counties that had populations that ranged between 11,000 – 150,000 but excluded single cities with population over 50,000. The counties varied in density, employment, and distribution in farming and non-farming communities. They study reveled that the homeless population in rural areas largely tended to be single woman or mothers with children, as they comprised 51% of the sample population with a median age of 26.8 years old. The women cited family violence or dissolution as primary cause of homelessness. They shared they were unable to transition out of homelessness because of inability to work because they lacked child care and have limited skills to compete in job market. They were predominately white but there was still an over representation of minorities compared to general population.

Similar to AHAR data, this study revealed that a large portion of the population tended to be transitionally homeless with median days of being homeless reported as 49 days and 90% of the population reporting being homeless for one year or less. Economic reasons, evictions, problems with paying rent, and unemployment were reported as the top factors that contributed to them becoming homelessness. With regards to resources, the income source tended to be a combination of employment, welfare, social security disability and supplemental income and pensions. This further supports Mosely & Millers (2004) that rural poverty is a condition of under-employment. Lastly, the respondents had a more nuanced need regarding affordable housing and cited lack of sufficient income to afford housing as more of an issue compared to lack of affordable housing. The findings from this study reflect, again, that the demographic of homeless in rural regions are women and female headed families and that they need both internal and external supports to help increase their self-efficiency and promote stability.

Government Accountability Office (2010) also wanted to explore service delivery to homeless population in rural areas and acknowledged a gap in sufficient empirical data. They reviewed existing data, conducted site visits to six states and interviewed federal, state, and local officials as well as shelter and supportive service providers and homeless individuals. Their research revealed that rural areas organized in to a mixture of rural and non-rural regions and noted the definition of homelessness and rural as problematic in compiling data and streamlining services. The varying agencies focus on a segment of homeless population and create incompatible data to analyze. They also noted there are high rates of mobility and a large geographical area for homeless to be dispersed (and help keep some invisible) making enumeration more difficult. Again, this highlights that using shelter use and shelter service counts as insufficient to collecting data on homeless in rural regions.

The study also analyzed environmental and individual barriers that maintained rural homelessness. With regards to individual barriers, the persons interviewed shared that mental health issues, felonies, lack of proper IDs, loan defaults, and uncompleted applications to housing programs as obstacles. With regards to external barriers, the study reiterated the scarcity of housing services and complete lack of shelters in some counties. As a result there are limited service providers that are over-extended and must cover large expansive regions. Service providers also shared they spent large portions of their time on paperwork and administrate tasks to maintain precarious funding and stay afloat and wished they could spend that time on direct services instead. There was also limited affordable housing and hazardous rural conditions, such as flood plains, exasperated safety of existing homes. The costs of maintaining safe structures are sometimes more than the value of the home. Lastly, and sadly, there is resistance by local communities to seek out funding, even though they qualify for services through various agencies including RHS, and build low-income housing and shelters because they perceive homeless individuals as undesirables and do not want them in their community- not in my back-yard syndrome. They mistakenly assume that lack of housing structure to service needs means the need is eliminated and leave most vulnerable members of their community, predominately women and children, to continue to suffer invisibly.

Services provided to homeless families. Case management is the primary method of providing services to people who are experiencing homelessness (Morse, 1999 & Rog, 2000). Although, is often the mode for providing services it continues to have broad and vague application. Shelter programs, 78% of them, use case management to provide services to sub-populations, such as those with severe mental illness, dual-diagnosis, substance abuse and homeless women and children (AHAR 2010). The definition of case management is best

conceptualized by the function of the role (Mueser, Bond, Drake ; Resenheck, 1998). Case management services often deal with properly identifying the client that needs the services and than moves to the assessment, planning, linkage, monitoring, and client advocacy phase. This maybe followed with discharge planning. The specifics of how case management services are provided vary according to: duration, intensity and focus of service, the availability of the case manager -office hours or 24 hour service and location of service- office or community based. Assertive community treatment, intensive case management, and critical time intervention are forms of case management and service delivery that have empirical supports and widely endorsed for providing effective supports for homeless populations. However, they focus on chronically homeless populations with severe mental health conditions. There are no comparable models for providing services for transitionally homeless population. However, it is useful to understand the services that work for segment of the homeless population to gain insight into effective practices and insightful frameworks that maybe adapted to serving transitionally homeless populations.

Assertive community treatment approach (ACT) developed by Test & Stein, (1976) has strong empirical support for treating non-homeless severely, mentally ill population, and adopting the model to serve chronic homeless population has yielded positive results (Latimar, 1999 & Nelson;Aubrey, & Lafrance, 2007). ACT model was developed as a form of case management service delivery for markedly impaired clients and contains clearly articulated treatment principals and practice approaches. Its comprehensive approach has the following elements: (a) multi-disciplinary team that typically consists of a nurse, case worker, and psychiatrist, (b) small shared case load, (c) community based (d) flexible service delivery with crisis management available 24 hours a day, 7 days a week and (e) has fixed point of

responsibility.

It aims to work with the most challenging individuals and does not discharge clients because they are non-complaint. Because the caseload is shared, the client has multiple resources and opportunities to engage with service providers in their own environments. The ACT team and client set up goals to increase independence (housing, activities of daily living, counseling) and use assertive directive approaches to shape behaviors. This includes allowing for negative natural consequences to hold client responsible for maladaptive behavior while supporting more appropriate behavior.

Intensive case management model (ICM) was also developed to the meet needs of high service users, like ACT, and employs low patient to staff ratio and provides assertive our reach in community environment (Shern, Surls, & Waizer, 1989). Similar principles and to ACT, it has low staff to patient ratio, high outreach to patients, emphasis skill training, high contact with direct in-vivo supervision of task, and is community based. In fact, the only overt distinction between ACT and ICT is in the ICT model caseloads are not shared with other service providers. ICT also tends to be more descriptive rather than prescriptive compared to ACT but in most cases because of the subtle differences the models are used inter-changeability.

Because of their similarities, ACT and ICT models are often adapted to community service contexts and yield positive results. The Nelson et al. study (2007) evaluated empirical studies that used ACT and ICM (used interchangeably due to similarities in models) to evaluate housing support interventions for mentally-ill homeless population and found the best outcomes for housing stability were in programs that contained housing and support, followed by ACT, and weakest effect size for ICM alone. Rog (2004) also reviewed 15 empirically published studies that included 5 RCT designs, on supported housing deigns with particular attention to

those with mental illness. She found supportive services positively impacted all housing outcomes over time, with those having access to affordable housing yielding the most improvement across all measures. When types of housing were closely examined the results mere mixed in terms of the effect of case management.

Lastly, critical time intervention model (CTI) was developed by mental health clinicians from Columbia University who were working with chronically homeless men with severe mental illness in New York City (Susser, Valencia, Conover, Felix, Tsai & Wyatt, 1997). An increase in transitional and permanent housing programs allowed for an expansion of services and created a greater need to support homeless individuals to not recvidivise or –re-enter in shelter services. Expounding on time-sensitive interventions, Herman and Mandiberg (2010) describe and summarize the continued work using CTI with chronically homeless population the and discuss empirical outcomes in the application of the model. CTI model is a time limited model that helps institutionalized individuals, primarily homeless, transition from institutions into community settings. The aim is to reduce risk of homelessness and other adverse outcomes by increasing long-term ties to formal and informal supports.

A key factor in helping achieving stability is to begin providing service to the individuals in the original institutional setting prior to discharge. Services are continued post discharge and most effort and energy is exerted in the initial stages of transition. Transitioning into community involves interacting with complex, fragmented, and complicated systems and having a trusted service provider help negotiate and navigate through in these systems in the initial stages of treatment is crucial. However, the aim of CTI is to also transfer primary care responsibility to existing supports in a planned and phase oriented process. The three phases of treatment are (a) transition from community, (b) try out and (c) transfer of care. This typically occurs in nine-

month period. Intensity and contact with client is concentrated in the initial transitional phase where the worker spends time with the individual in community setting and helps set goals and accompanies client to appointments with other service providers. This is similar to ACT in-vivo treatment protocol but is less ambitious and focuses on eventually transferring care to other service providers. However, the transfer is not an abrupt ending of services but a planned process that typically takes a month.

ICT effectiveness was measured by three RCT trials (Kasprow & Rosenheck, 2007; Susser et al., 1997) that included shelter programs and medical centers with Department of Veterans' Affairs. The subjects were discharged from inpatient psychiatric facilitates and large municipal shelters. The studies revealed a significant reduce in risk post discharge homelessness, compared to treatment as usual case management services or intent-to treat programs. A secondary analysis of CTI condition also revealed that more contact with worker before discharge to community revealed improved results compared to those who received little or lesser pre-discharge contact. Indicating the importance of the initial quality of the relationship between the individual and the service provider. As a result of these findings, CTI has been endorsed as one of the best-practice models by the Substance Abuse and Mental Health Services Administration and as well as by the Public Health Agency of Canada.

It is important to note that ACT, ICM, and CTI studies continue to focus the non-transitional homeless and do not specifically address the case management needs of homeless women and children, although they continue to be the largest sub-group of homeless families. Because housing is often the focus, other health measure, including psychological and self-efficacy, are not overtly addressed. Acknowledging the needed supported services to homeless families, Bassuk, Volk, & Olivet (2010), prominent researchers in field of homelessness, propose

a useful tiered framework that incorporates existing phase sensitive and intensive service deliver such as ACT and CTI with needed supports for experienced trauma that impedes continued stability. Their proposed three tiers focus initially on the basic services and transitional supports that all homeless people need such as affordable permanent housing, jobs, childcare, health care, transportation and basic services for children. The second tier consists of specialized services that can target specific needs of clients after meeting the basic needs addressed in tier one. The last tier, consisting of 10% of population, may require ongoing life-long and income supports and maybe serviced by multiple service providers and through the use of researched models such as ACT or CTI.

Tier II supports are particularly useful for transitionally homeless populations because they include an array of specialized services that help homeless families exit shelter programming and maintain permanent housing. These ongoing supports include additional and targeted support in education and job opportunities, services for traumatic stress and mental health, increasing parting supports, and services fro children. Trauma informed service delivery, a Tier II support may enhance overall stability and is worth evaluating with regards to serving homeless families. Trauma-informed care and services acknowledge the context in and environments that people receiving services experience and has the capacity to help address critical issues with regards to internal and external barriers for homeless women addressed in this paper. It provides tools to help individuals negotiate through painful transitional periods that often retraumatize or re-trigger their already vulnerable states. It is important to understand trauma studies and interventions to understand its applicability to homeless populations, specifically homeless women.

Trauma Theory and Trauma Perspectives

Because trauma studies have been gaining prominence in the social sciences, it is important to delineate what constitutes trauma theory and treatment versus trauma perspective or framework. Trauma theory, as conceptualized by Judith Herman (1992), places the traumatic event and system as the central and underlying focus of conceptualization of theory and treatment. Herman asserted that trauma is the catalyst for pathogenesis; she posited that the direct treatment and focus on trauma, often in phase-oriented treatment, will help alleviate symptoms on varying levels.

On the other hand, trauma perspectives or trauma frameworks incorporate the influence of trauma into existing paradigms. This can be seen in developmental theory, such as attachment theory, where the inclusion of the individual's trauma is incorporated into the assessment of the attachment style of the infant and its potential to influence future functioning (Williams, 2006). Trauma can also be the focus of existing treatment modalities such as trauma-focused cognitive behavioral therapy (TF-CBT), where phase-oriented treatment of trauma therapy is utilized along with typical elements of CBT, such as cognitive coping as well as *en vivo* mastery of trauma reminders (Cohen, Mannarino & Delblinger, 2006). Moreover, an organization or service provider can be categorized as trauma-informed. Systems may serve trauma survivors without directly treating the trauma. Trauma-informed service delivery is conscious of the effects that trauma can have on the targeted population and is committed to providing services in a manner that is sensitive to trauma survivors (Harris & Fallot, 2001).

Both trauma theory and the incorporation of trauma into existing frameworks reflect the relevance of trauma in research and practice, and bring attention to the influence of trauma. These two theories of trauma treatment help create systems that are sensitive to vulnerabilities

brought on by trauma, and help reframe paradigms that do not account for the residual effects of trauma. However, it is important to note whether a treatment modality and perspective is exclusively trauma focused, or if takes into account traumatic experiences as part of a larger framework; each model has significance for practice.

Defining trauma. Suffering and trauma have consistently been part of human history and narrative. Van der Kolk (1996) stated, "experiencing trauma is an essential part of being human; history is written in blood" (p. 47). The systematic study of human suffering and its effect on the human psyche is at the heart of behavioral sciences, especially social work. Trauma is not merely the experience of a stressful event, but rather consists of experiencing and perceiving an event as life threatening and overwhelming; trauma compromises ordinary adaption by rendering the individual helpless and powerless. In her seminal writing, Herman (1992) described trauma as an experience of intense fear and helplessness accompanied by loss of control. Caruth (1996), a noted trauma scholar, adds that trauma is the experience of the connection between the psyche and external violence. She described trauma as the imposition of horrific events on the body and the experience of the outside coming in without being mitigated. Caruth asserted that survival is the central problem of experiencing a traumatic event. Someone experiencing trauma must live through a life threatening experience and then grapple with the residual effects of the event.

The classification of post-traumatic stress disorder (PTSD) in the 1980 as a diagnosis in the *Diagnostic Statistical Manual of Mental Disorders* (DSM) helped create a framework for categorizing and defining the experience of trauma. Clinical PTSD symptoms are defined as experiencing, witnessing or facing/perceiving an event in which the life or physical integrity of the individual was threatened by death, and they reacted with extreme fear and helplessness. The clinical syndromes associated with PTSD involve re-experiencing the traumatic event, avoiding

stimuli associated with the events, and increased arousal (APA, 2000). To qualify for a clinical diagnosis of PTSD, these symptoms must last for more than one month. The creation of PTSD diagnosis helped to alleviate the stigma of neurotic, mysterious symptoms associated with trauma and helped place a label on a common disorder (Van der Kolk, McFarlane, & Weisaeth, 1996).

There is distinction between being in a traumatic event and responding to a traumatic event. The affective response to a traumatic event that is associated with a biological response; this determines the pathological effect of the trauma (Van der Kolk, Pelcovitz, Sunday, & Spinazzola, 2005; Sterling, 2012). However, having witnesses to and labeling and organizing a disturbing experience is essential to determining effective treatment for most experiences. Mitigating the long-term negative effects of a traumatic event requires making meaning through adequately naming the experience and/or integrating the affect and cognitive experience of trauma (Abaibi & Wilson, 2005).

Types of trauma. Definitions of trauma and traumatic experiences have expanded to include Type I and Type II trauma, or complex trauma, historical trauma, and secondary or vicarious trauma. Basham (2008) delineated Type I and Type II traumas as conceptualized by Lenore Terr. Type I trauma is described as a single event of catastrophic proportion such as a natural disaster, violent act, death, loss or threatened loss of family, friends, and community. Type II trauma includes chronic and repetitive abuses experienced predominately in childhood. However, this can include adults who are entrapped and have also experienced repetitive abuse.

Feeling that the PTSD typology classification did not fully accommodate the wider range of responses to traumatic experiences, Herman (1992) introduced the concept of complex posttraumatic-stress disorder. This concept has been called complex trauma, or disorders of

extreme stress not otherwise specified (DES-NOS), and is conceptualized as cumulative trauma caused by multiple factors including interpersonal iolence, neglect, or abuse (Kilpatrick, 2005; Pearlman & Courtios, 2005; Williams, 2006). In these circumstances, the response to the trauma can range from brief stress reactions to major negative developmental expressions in perceptions of self and others. Social and historical traumas are defined as large-scale collective traumas sanctioned by the majority in power. These include genocide, wartime conflicts, slavery and internment camps (Stozier & Flynn,, 1996). International social workers and social workers working with soldiers often encounter populations facing these conditions.

Lastly, working with traumatized populations can create vulnerabilities for the helper; this is conceptualized as vicarious or secondary trauma. Craig and Sprang (2009) described secondary trauma as "transformations in cognitive schemas and belief systems as a result of empathic engagement with survivors of traumatic experiences" (p. 320). Saakvitie (2004) reiterated that exposure to trauma cases can result in inner transformation of the helper by negatively disrupting meaning and worldview. This, in turn, negatively effects treatment the clinicians provide and may lead to earlier incidents of burnout. Secondary trauma may be an especially relevant issue for preparing future social workers. Behavioral health professionals, including social workers, often have trauma as part of their personal background (Alpert & Paulson, 1990; Bride, 2004; Horton, Naelys, & Green, 2009), and must be adequately prepared by being self-reflective and aware of their reactions to clients with trauma and appropriately create self-care plans (Cunningham, 2004).

Having a wide net to define trauma and responses to trauma gives a wide domain for practice because it targets different parts of system for service delivery. These definitions explain the effect of the environment, as experienced through trauma, on the person and system and help

to create meaning in individual experiences. Trauma theory values the experience of the individual and attempts to explain pathological symptoms within context; trauma theory is interested in how the persons processes and internalize or externalize his or her experience, (Herman, 1992).

In a larger context, systematic and historical definitions of trauma take into account how the interaction of trauma is expressed in systems, and how silence or denial of the trauma perpetuate abusive and non-responsive systems. A trauma-based perspective allows for a flexible view of human nature and development and assumes that pathology is not always inherent (Bremmer, 2003; Ganzel & Morris, 2011; Evans et al., 2007; Van der Kolk, 2002) Instead, this perspective acknowledges that unresolved or untreated trauma can lead to negative psychosocial interactions. Defining trauma in a concrete manner and allowing the response or experience of the perceived trauma to be applied at the micro, mezzo, and macro levels gives social workers language and a paradigm for practice based on what is known about trauma and its treatment.

Historical context of trauma theory. Herman's (1992) historical and clinical study of trauma provides a paradigm for current trauma theory. Her historical analysis of trauma from a feminist perspective sheds light on the oppressive historical and delegitimizing treatment of victims, and provides a context for a more inclusive and culturally responsive analysis the subject. Herman's historical critique of trauma history narrates the political and policy transformations that helped reconceptualize trauma theory and treatment. Herman rejected trauma as a natural part of human experience, instead addressing it as organized violence through silence and denial. She highlighted the influence of Freud and Janet, along with the additional influences of wars, feminist movements, and the classification of PTSD in the DSM as the contexts that allowed for trauma theory to emerge.

Freud and Janet. Herman (1992) traced the systematic study of trauma through the study of hysteria symptoms that were described in Victorian culture as bizarre psychosomatic symptoms mostly effecting woman. Freud's entry into behavioral sciences began with the study of hysteria. His qualitative study of patients suffering from hysteria revealed trauma, particularly incest, as the common experience of women. This observation led to his seduction theory as the etiology for hysteria. However, he later rescinded his theory because too many women were reporting sexual abuse and he could not conceive this level of abuse. Instead, he replaced seduction theory with an exaggerated form of the Oedipal complex (Strozier & Flynn, 1996), and treated them with psychoanalysis. Freud's rejection of seduction theory derailed what could have been the foundation of trauma theory. Herman argued that his dismissal of women's experiences set the tone for the marginalization of traumatized populations.

A lesser-known contemporary of Freud, Pierre Janet rejected Freud's seduction theory and linked traumatic experiences to disassociation and amnesia. He suggested that self-regulation through affective reintegration of traumatic memories relived traumatic symptoms (Brown, Hart, & Graaflan, 1999; Heim & Buhler, 2001). Janet rejected dissociation as rooted in fantasy and developed cognitive and sensory motor treatment staggered in phases to help integrate traumatic memories and relieve amnesia. Unfortunately, Janet's work and theories on trauma died with him and his work did not spur more inquiry until contemporary trauma theorists who believed that dissociation was the main agent for the development of PTSD symptoms emerged (Bryant, 2005; Van der Kolk, McFarlane, & Weisaeth, 1996). Although Janet's theory and work was not as celebrated as Freud's work was, his theories of dissociation, affective memory, and integration of memory into larger consciousness provided the cornerstone for treatment of trauma in both psychodynamic and current trauma theory.

War and feminist movements. Epidemic suffering caused by war is often a catalyst for the descriptive and systematic study of trauma. Trauma or hysteria studies fell from popular culture until World War I forced the medical and psychological community to revisit hysteria. World War I and II brought the discourse of trauma into public domain because of the devastating effects of these wars on the mental psyche of large sectors of society. Soldiers began exhibiting mental and physical breakdowns very similar to hysteria. They suffered from amnesia and presented with extreme somatic symptoms that included blindness, mutism, fugue states, and disturbing dreams (Herman, 1992). This expanded the discourse on the systematic effects of trauma into the male population and rebuffed the notion that traumatic neurosis as solely attributed to women.

Initially, psychiatrist Charles Myers believed that repetitive exposure to exploding shells caused the physical symptoms of war neurosis; he famously called this shell shock (Moskowitz, Schafer, & Doorway, 2008). However, soldiers who were not exposed to physical trauma also began exhibiting similar symptoms. This made combat neurosis a psychological problem, and it was assumed that soldiers with weak mental constitution or moral character suffered visibly from the effects of the war. As the war continued, more progressive medical authorities argued that people with high moral characters were also suffering (Van der Kolk, 1998) The goal of treatment was to rehabilitate soldiers so they could return to combat.

Specifically, Abram Gardiner was a medical psychiatrist who specialized in combat neurosis and his clinical formation of traumatic syndrome mirrored Janet's work (Van Der Kolk, McFarlane & Weisaeth, 1996). In World War II, military psychiatrists attempted to remove the stigma associated with stressful reactions to combat by normalizing psychological stress and

finding ways to treat factors that induced breakdowns (Moskowitz, Schafter, & Dorahy, 2008). Thus, the political and social climate began making space for trauma.

After World War II, attention to the systematic effect of trauma ceased until the Vietnam War. Vietnam War veterans began forming rap groups to detail the effect of war on their psychological health and to raise public awareness about their suffering. This led the Veterans Administration to conduct research tracing the effect of war experiences and scientifically legitimized the traumatic effect of war (Marmar et al., 1994). Documentation of PTSD and its symptoms, including inclusion in the DSM in 1980s, indicated that traumatic symptoms were formally recognized as a factor in psychological health.

Contemporary conceptualizations of trauma. The classification of PTSD symptoms legitimized traumatic experiences as having adverse health impacts to individuals and communities. In the 1970s, feminist conscious-raising movements also began to shed light on the private trauma that women and families experienced (Herman, 1992). Women investigators began conducting research and were able to contextualize the sexual and physical violence women experienced as a systematic trauma that induced control and terror. They advocated for legislation around rape and domestic violence, and gave voice to the victims of trauma. Women were no longer forgotten or delegitimized in their traumatic experience. Female researchers gave weight and voice to the original findings of Freud and Janet and caused macro changes.

Current research and literature on trauma builds on the social and political work of military and feminist researchers. Feminist researchers helped create safe places for victims to share their experience and empowered them make choices about their treatment. In turn, trauma responsive institutions were created and provided settings that legitimized the experience of victims that typically come from oppressed groups. The Department of Defense (2012) is

allotting $100 million for research to improve and better treat the effects of traumatic brain injury and PTSD. The analysis of trauma through the eyes of the victim reframed the injury of trauma as the focus as opposed to the victim (Gilmore, 2008). The reconceptualization of power, victimization, and redress helped contextualize trauma studies. Healing from traumatic experiences can begin when the violence and trauma victims have experience is recognized as harmful by legal and social structures.

Anatomy and physiology of trauma. As a result of over 30 years of research, trauma studies have been examining the long-term physical, emotional, and social toll that exposure to traumatic experiences, especially in childhood, creates, and the damage that can result from severe and recurrent exposure to threat and stress (Bremmner; 2003; Bynum et al., 2011; Courtois, 2004) . Integration of research from biological and social sciences such as neurology, medicine, and human development elucidate the relationship between stress and health (Ganzel, Morris, & Washington, 2010; Herman, 1998; McEwen & Wingfield, 2002; Sterling, 2012). This has created a framework to better understand how traumatic or adverse events, experienced as stress, effect brain, human system, and overall functioning.

The human brain is central in mediating ongoing stress, and facilitates adaptive physiological responses by regulating internal and external states (Bremner,1999). To understand and treat the effects of trauma, it is important to understand the impact trauma has on the brain, development, and ways of relating. This understanding provides insight into what can seem like chaotic behavior in clients that have trauma in their history, such as homeless women, and provides a framework to provide more holistic and responsive treatment.

Brain structure and development. Neurological research has integrated social and health sciences by highlighting the central role of the brain in development while simultaneously

acknowledging the impact that context and environment play in shaping the developmental process (Ganzel & Morris, 2011; Greenough, Black, & Wallace, 1987; Schore, 2003). A basic understanding of brain structures and development is necessary to understand how traumatic stress affects the brain and functioning (Bremner, 1999). At the foundational level, neurons, nerve cells that transmit information, are the building blocks of the brain and central nervous system (Buonomano & Mezenich, 1998). Neurons sense, process, store, and perceive information to mediate a set of specific functions. Neurons integrate information from multiple sources, interconnect, and form neural circuits that create representational information codes. They organize into specialized structures in regions of the brain to perform regulatory functions that promote survival and adaptation (Giedd & Rapoport, 2010). Brain development is sequential and hierarchical, and neural development is dependent on timing (Hensch, 2004; Schore, 2003).

The oldest part of the brain is at base of the brain and consists of the brainstem and medulla, which are responsible for automatic survival functions such as heart rate and breathing (Schore, 2003). The thalamus sits atop the brain stem and acts as the switchboard that relays messages to the more developed forebrain. The limbic system is part of the forebrain structure that contains the amygdala, hippocampus, and hypothalamus (Gould, Beylin, Tanapat, Reeves, & Shors, 1999) . The limbic system is central in processing emotional stimuli and is critical to understanding effect of stress. Specific structures in the limbic system will be discussed later in their role in memory formation and affect regulation.

The cerebral cortex, divided into right and left hemispheres, contains four lobes. It is the central processing center for higher processes including language, visual, auditory, and sensory data (Schore, 2003). The highly connected regions of the brain, along with the peripheral sympathetic nervous system and other biological processes such as the nervous, immune, and

endocrine system, organize to translate environmental stimuli, including stress, into behavioral and psychological responses (MCEwen, 2007).

The ability to create internal representations of the external world is dependent on the pattern of intensity and frequency of neural activity modulated by the sensory processing of experiences (Esparaza et al., 1995). Neural responses to environmental stimuli enhance adaption in systematic manner as hormones and nuerorophins, proteins that promote survival, develop neural circuits and templates (Herman, & Cullinan, 1997; Karatsores & McEwen, 2011). Experience becomes the mode in which neural networks create templates through which new data is processed and interrupted (Greenough, Black, & Wallace, 1987). Cells become more likely to respond to neural stimuli after multiple exposures in a process called sensitization (Perry et al., 1995). Once sensitization occurs, the same activation can be elicited at lower activation levels because the circuits and signal pathways have become stronger (Gould et al., 1999). Early relational patterns and interpersonal interactions organize into neural networks that become sensitized and process emotions to make meaning of sensory information and relationships (Schore, 2003).

Appropriate neural activation is needed at a set time for continued development, and early experiences mediate the levels of development (Hensch, 2004). Critical periods require specific stimulation for optimal organization and development, and postnatal development has time-sensitive windows that may promote plasticity, or be especially vulnerable to the deleterious consequences of stressful stimuli (Ganzel & Morris, 2011; Hensch, 2004). Structural maturation and development is associated with periods of high activity in early childhood, late childhood, puberty, and mid-adolescence (Kepermann, Kuhn, & Gage, 1997; Matsuzawa et al., 2001). These developments correspond with cognitive and emotional development and are

associated with a child's ability to appraise and assess their environment to respond to danger (Pynoos et al., 1997; Shonkoff, 2011).

Other biological systems such as the nervous system, endocrine system, and immune system also mature after birth and enter a process of pruning, in which unstimulated or unused neural structures and circuits are eliminated (Ganzel & Morris, 2011; Hensch, 2004). In some instances, critical period deprivation may result in irreversible neural atrophy, while other processes can wait to be elicited later without the same consequences, creating the possibility of continued plasticity in adulthood (Hubel &Wiesel, 1970; Matsuzawa et al., 2011). This highlights the effect that timing, intensity, duration, and type of adversity experienced by child can influence the trajectory for stress response and adaptation (Danese & McEwen, 2012).

With regards to structural development and self-appraisal, the right and left hemispheres of the brain play a role in construction of cognition and development of self (Greenough, Black, & Wallance, 1987;Schore, 2001). The cerebellum is divided into two sections; the right universal brain and the left verbal brain (Schore, 1996). Early development of self is largely constructed by the development of the right brain. Self-regulation structures are located in the right universal brain and neuro-imaging studies reveal that the brain increases in mass the first two years after birth (Masuzawa et al., 2001).

Typically memories are integration of language structures as well as non-verbal structures that consist of cognition that incorporates sensory information (Jarrrard, 1995). However, under duress, the body enters into a hyperarousal state that assesses threats more rapidly and places less emphasis on complex reasoning, which is less useful for swift action (Morilak et al., 2005). Because these memories are largely sensory-based, after the threat, images or other sensory inputs of the traumatic event may unwittingly trigger memories that the

individual may not fully grasp in their current state (Bremmer, Elzinga, Schmahl, & Vermetten, 2003; Krischbam et al., 1996). If recurrent, these flashbacks and attempts to avoid flashbacks can be the genesis of PTSD syndrome (McEwen & Sapolsky, 1995). Thus, treatment protocols that call for verbal processing of traumatic events help provide a narrative; a verbal memory of the event can help the mind and body integrated sensory information to provide meaning (Courtois, 2004; Rothchild, 2000).

Not all cortical circuits are fixed and can be modified by experience; this phenomenon is known as the 'all or nothing' or 'use it or lose it' construct of neural development (Buonomano & Merzenich, 1998). Synaptic plasticity allows for cortical reorganization, and activity-dependent plasticity can be elicited from peripheral structure (Mahncke et al., 2006). This gives great hope that new relationships and experiences can literally help rewire the brain and reinforce new experiences and relationships that can shape development and responses to stress (Doige, 2007).

The integration of attachment frameworks to the biological process demonstrates how early relational patterns influence personality and human development (Danese & MCEwen, 2012; Hanson. Et al., 2010) Before exploring relational theory and patterns, it is important to understand how stress and threat elicit a physiological response that influences neural networks and their development. This will highlight how early traumatic stress and invalidating relationships and environment create pathology, poor health, and increase/promote vulnerability at the neural level.

Stress and allostatic response. Traumatic or adverse stimuli are appraised as stress by the brain and body (Sterling, 2012). Stress research has its origins in the work Hans Seyle who built on the work by Walter Canon (Selye 1956). Seyle defined stress as unique demands, both

pleasant and unpleasant, made upon the body that needs a response to accommodate the demand. Stressors are non-specific, and in the body's attempt to reach internal equilibrium when threatened, it responds to the demand through a process called homeostasis (Cooper, 2008). He called the systematic response to stress *general adaptation syndrome* (GAS). Seyle posited the body's adaptation to threat generates a sequenced system response that includes heightened activity in the hypothalamus that produces corticotrophin-releasing hormone (CRH). CRH produces cortisol, which mobilizes the body to act in response to the perceived alarm and threat. The GAS response is a three phase system; the first stage involves the alarm stage as described above. This is followed by resistance, the second phase during which there is a decline in the overall response. If the stressor persists and overwhelms the system, it can lead to the last phase, exhaustion, during which the finite limits of the body to generate energy are depleted.

Seyle's work had great impact and influenced biosocial fields in their understanding of the human body and the factors that influenced development, maintenance, and function (Cooper, 2008). It also simultaneously highlighted the role context plays in survival and the responses to stressors that determine health outcomes (Ganzel, Morris, & Wethington, 2010) . However, ensuing research noted variations in the types of stressors and the mediating role of cognition, appraisal, and emotional regulation in response to the stress process, and demonstrated the classic homeostasis model needed modification (Bremner, 2003; Danese & McEwen, 2012; McEwen, 1998). The type, frequency and level of stress affected the body in varying ways and the single universal response as proposed by the homeostasis model was limited.

Sterling and Eyer (1981) introduced the concept of allostasis as a revision of the homeostasis model. They stated that homeostasis is not sufficient for daily adaptation and survival. They proposed the body is not simply attempting to reach equilibrium, but is seeking

survival in the most efficient and adaptive manner This survival process entails analyzing large amounts data from internal and external resources and anticipating need and changes in the environment so the biological system can respond before there is an error (McEwen, 2007).

Appropriate responses to the external environment require monitoring and processing inhibitory and excitatory processes in the different biological systems to regulate needs (Sterling, 2012). Anticipating needs and predicting the time of need requires information from peripheral sensory systems as well as lower physiological processes; certain stimuli or stressors may activate a chain of events to respond to anticipate need (Karastoreos & McEwwn, 2011). In order to maximize survival, multiple biological process work together. This integration is evidenced in response to psychosocial stress. During stress, the systems that respond to threat are HPA axis (consisting of the limbic and endocrine system), metabolic systems, cardiovascular, and immune systems (Herman & Cullinan,1997). Togther, these systems implement what is commonly known as the *fight or flight response* (McEwen & Gianaros, 2011). Stressors are appraised through neurobiological netwtsororks, and norepnrine stimulates the sympathetic branch of the automatic nervous system, which leads to secretion of epinephrine into the blood stream (Karatsoreos & McEwen, 2011). This induces a cardiovascular response such as increased heart rate, blood pressure, and cell metabolism to prepare for action (Morillak et al., 2005).

Simultaneously, the hypothalamus is also stimulated and responds by a secretion of corticotrophin releasing hormone that stimulates the pituitary gland, which stimulates the adrenal cortex to secrete cortisol (Herman & Cullinan, 1997). Again, most cells have receptors that respond to cortisol by increasing glucose availability to respond to the stress that invoked the reaction (Esparaza et al., 2012). The way threats are perceived is a psychological process; those with more adaptive functioning will respond in less physiological manner because their system

has built in buffers and is able to predict and effectively respond to stimuli . Moreover, cognition, learning, and recalling how the body and system responded to similar stressful stimuli in the past prompts survival (Karatsoreos & McEwen, 2011).

Therefore, the structures in the limbic system, the amygdala, responsible for processing emotion and specifically modulating fear responses (fight or flight), the hippocampus for memory processing, and the hypothalamus hormone regulation through the pituitary gland are critical in the stress response and process (Phillips & LeDoux, 1992). Structure formation and function, shaped by experience, create the ecology for continued development and how self and the relationship with others are constructed (Schore, 2003). This is critical to understand because service providers need insight on how the survival and coping behavior of clients in current contexts are shaped and influenced by early biological and contextual conditions. The residual effects of chronic and cumulative stress on the developing brain create extreme vulnerability that will continue to present in adults and helps explain the multiple behavioral and health risk factors seen in homeless populations (Katz, Sprang, Cooke, 2012).

Although adaptive, allostasis process has a price. These processes promote short-term adaption, but chronic or repeated exposure to psychosocial stressors places strain on the allostatic system and produce allostatic load, and in its most severe form, allostatic overload (McEwen, 1999; Sterling, 2012). The long-term effect of the allostasis process causes wear and tear on the body and influences health trajectory (Danese & McEwen, 2012). Furthermore, in some instances the process may be overactive or underactive and cause delays or disruptions in the adaptation. Adversity and trauma influences the physiological process and may induce illness and morbidity (Karatsoreos & McEwen, 2011; McEwen, 1998; McEwen & Sapolsky, 1995). This revision of the stress model and reconceptulization as allostatic process integrates

neuroscience and life and applied science and this expansion allows for the analysis of current stressors, as opposed to the old model in which past stressors solely assessed (Ganzel, Morris, & Weithgton, 2010). Accommodating current stressors into model delineates the ongoing development and the influence of current and past context in shaping brain physiological and responsive behavioral development.

Attachment and development. The prior discussion on brain plasticity indicated that post-natal brain development has critical time periods that require activation by internal and external sources (Buonomano & Merzenich; Greenough, Black & Wallace, 1987; Giedd & Rapport, 2010; Matsuzawa et al., 2001 . Therefore, the context and environment the infant lives in is critical for physiological development, personality formation, and relational patterns that promote survival. Attachment theory and framework focus on the influence of early relational patterns between caregiver and infant (Fonagy, 2001). The advances in neurobiology, in cooperation with other interdisciplinary data, extended the existing body of literature on attachment as critical components to developing structures in the brain that are involved in processing emotions, modulating stress, self-regulation, and the cognition and construction of implicit self (Bowlby, 1977; Schore, 2001; Schore & Schore, 2007), Attachment theory has its genesis in work of psychoanalyst John Bowlby in the 1950s, and was further developed by the work of Mary Ainsworth and Mary Main (Bowlby, 1977; Shilkret & Shilkret, 2008).

Bowlby (1977) conceptualized attachment as the tendency of humans to make strong affection bonds to others for physical and emotional survival. Early attachment becomes the basis of internal working models of attachment in which internal templates or schemas define close relationships. Maintaining proximity to someone who is perceived as stronger and wiser does this, and attachment behaviors endure over a lifetime (Gould et al., 1999; Evans et al, 2007;

Kempermann, Kuhn, & Gage, 1997). Strong attachment figures or caregivers provide secure base for individual to explore and develop healthy perception of self. Attachments are not described in terms of strength, but in terms of quality as secure and insecure.

The attachment patterns outlined by Bowlby (1977) were elaborated by Ainsworth in her formulation of secure or insecure attachment, and Main added to this with her conceptualization of disorganized attachment and her work with adults (Shilkret & Shilkret, 2008). Attachment theory focuses on the real life experiences of infants, and asserts that there is direct relationship between individual experiences with a caregiver and future capacity of making affectional bonds.

In infancy, critical periods of development are influenced by relationships and the brain is essential socially constructed in the beginning (Chiron et al., 1997). Communicating emotional states is central to development process. Early relational patterns and interpersonal interactions organize neural networks to process emotions and make meaning of relationships (Greenough, Black, Wallace, 1987) . Early experiences and interactions influence neural pathways and inform the relationship between the world and self (Perry et al, 1995; Ogawa et al., 1993).

Environments that are predominately full of stress, fear, and trauma become encoded into the neural networks of children's developing brains (Bremner, Elzonga, Schmahl & Vermetten, 2008; Duman, Malberg, Nakagawa, & D'Sa, 2000). This leads to a disturbance in relationship between self and environment (Feinberg & Keenan, 2005). However, attachment to a nurturing caregiver that provides protection helps develop strong self-regulatory structures in the brain. Therefore, a responsive caregiver who is predictable and able to be manipulated by the child to meet his/her needs can create a positive arousal that contributes to development (Schore, 2001).

Accordingly, mother or caregiver must be attuned to the biological and internal states of the child and be responsive to differing states of arousal and affect (Liberman, 2004). The

relationship mediates the developing central and autonomic nervous systems. A caregiver is attuned to periods of engagement and stimulation, as well as periods of recovery and disengagement; this helps create homeostasis, mostly in nonverbal communication (Schore, 2003). This involves facial expression, tone of voice, body posture, and gestures. There can be missteps in the attunement process, but those missteps are inherent in the attachment process and actually help the infant develop resilience in the presence of stress and novelty.

Thus, emotions are initially regulated by the outside relationship, but as maturation occurs and the infant becomes self-regulated, adaptation skills are developed. This is reinforced in neurobiology in which interactions between mother and child improve synaptic connections in the establishment of circuits in right hemisphere of brain that are responsible for emotional, stress, and regulation processes and ultimately the self-system (Buchheim 7 Mergenthaler, 2000; Miller et al., 2001).

Disruptions in the care giving relationship create vulnerabilities in the sense of self and others (Fongay, 2001). Pathogenic care giving styles such as unresponsiveness to the child's care-eliciting behavior or the sheer absence of parents causes disturbances in development and creates barriers for the individual to see himself/herself as worthy of help or helping himself/herself (Bowlby, 1977). This is critical to understanding the effects of stress and trauma in the developing self, both biological and psychological. Being aware of this process and becoming trauma-informed radically affects the climate and type of interventions given to clients. Fundamental understanding of stress on the human system by service provides helps create an empathic and less punitive treatment framework that helps the attunement process in the service delivery that promotes plasticity, resilience, and healing.

Influence of stress in development. Disruptive care giving and toxic environments influence development, and understanding this is critical to understanding how people come to have pathological adaptations that stem from stressors (Ganzel & Morris, 2011) . The impact of trauma is most salient in childhood, but is often the most minimized (Perry et al., 1997). Children exposed to unpredictable man-made violence are most vulnerable (Bloom & Farrangher, 2011). When raised in stress and trauma filled environments in which expectations of protection were met with even more trauma, brain architecture becomes altered (Bremner, 2003). Disruptions during critical periods can be caused by lack of stimulating sensory experiences or abnormal neural development due to exposure to extreme or adverse activity (Evans et al., 2007; Katz, Sprang & Cooke, 2012). The younger the person is when exposed to trauma, the more powerful the disruption of development (Bremner, Elizinga, Schahl & Vertemmen, 2008).

Chronic exposure to trauma produces hyper sensitivity to threat, and can produce large and inappropriate responses to current minor issues (Heim & Nemeroff, 2001). This is even more pronounced when the cause of trauma is the attachment source, or when there is an unplanned separation or abuse from the attachment source; this is often seen in interpersonal violence (Ogawa et al., 1993) Deprivation, lack of a nurturing attachment figure, and continual threat significantly influence neural circuits and produces emotional dysregulation (Anda et al., 2006).

Response to threat can lead to hypersrousal and/or dissociative states as a way of preparing to respond to threat or to understand the magnitude of threat, enter into a denial state to minimize the impact of the threat (Phillpis & LeDoux, 1992). Because children are small and vulnerable, a common reaction to threat is to cry or vocalize fear since they cannot act on their fight or flight instincts (Herman, 1998). If there is an unresponsive caretaker a child can engage in continuum of responses, including a freezing dissociative response in which they disengage

from external stimuli and go inward (Perry, 1995) This can look like a glassy disengaged affect, or daydreaming response, or in some instances full loss of consciousness.

There is a physiological response during disassociation, similar to biological response to opiates, in which the dopamine system is affected and pain and sensory processes are affected (Moskowitz, Schafer, Dorahy, 2008). The neurobiology of disassociation is linked to amino acid glutamate, which is associated with toxicity to hippocampus cells (Bremmer, 2003; McEwen, 1999). The smaller volume of the hippocampus is related to dissociative states, and this is often seen in women with early abuse backgrounds (Hanson et al., 2010; Jarrad, 1995; Van der Kolk, 2002). Moreover, stress lessens the branching of neurons associated with the hippocampus and cell regeneration (Bremmer, 1999) . Memory structures, hippocampus, prefrontal cortex, and amygdala are affected by stress, more specifically declarative or explicit memory (Bremner, 2003; Kirschbaum et al., 1996). Stress can induce the release of hormones in the hippocampus that causes deficits in memory function, and the progressive atrophy of cells and lead to "accelerated ageing (Herman & Cullinan, 1997; Danese & McEwen, 2011).

Maltreated children have smaller pre-frontal cortex volume compared to non-maltreated population, and they also tend to have larger amygdalas (Danese & McEwen, 2012; Giedd; 2010) from chronic activation of HPA system. They also show higher levels of inflammation, as if they are perpetually preparing to fight pathogens in non-threatening situations (Anda et al., 2005; Hanson et al., 2010). Adults showed smaller prefrontal cortex volume, variation in size of amygdala, smaller hippocampus volume, chronic activation of HPA axis, and elevated inflammation levels (Bremner; 2003; Kirschbaum et al., 1996; Kempermann, Kuhn, & Gage, 1997). Therefore, adverse childhood experiences are influential, and in some cases predict, adult neurobiological changes.

Following threat, there is an acute fear response that can be easily reactivated by specific reminders of the event or even thoughts or dreams (Peralman & Courtois, 2005). These responses, once adaptive, can become generalized and easily reactivated and sensitized (Perry et al., 1995) . This leads to dysregulated internal states that are expressed in functional impairment in relationships and behavior (Sterling, 2012). Often this looks like hyperactivity, sleep disturbance, impulsivity, and psychological disorders. Hypervilgilance can lead to anxious states because traumatic flashbacks or associated feelings can be triggered by neutral or unknown stimuli that promote continued vigilance. In some instances, children freeze in the face of trauma; behaviorally, this can look like defiance and the willful tuning out of an authority or care giver, when it is actually a maladaptive response to cope with intense anxiety and terror (Katz, Sprang, & Cooke, 2012). This response causes an escalation in demand by the caregiver or adult, which makes the child even more anxious.

In young children, boys tend to express their dysregulation with externalizing behaviors and often come into treatment for ADHD or disordered behavior, while girls tend to internalize and use dissociative defenses more (Pynoos et al., 1997). Later, this type of coping in women can develop into borderline personality traits in which strong affect is not well tolerated and dissociative defenses used in childhood are frequently used to cope with intense feelings (Lieberman, 2003) In the developing and maturing brain, these internalized neural systems can develop into persistent fear states or traits that evolve into enduring personality traits (Perry et al., 1995).

Adult response to stress. The defensive action system in which emotions serve as mental radar to alert a person to impending threat through wired automatic system continues into adulthood (Sterling 2012). Poor early attachment experiences and disorganized attachment leads

to difficulty in regulating internal states and managing strong negative emotions such as fear and shame during adulthood (Duman, Malberg, Nakagawa & D'Sa, 2000). Defensive hyperarousal, dysregulated states, and dissociative tendencies become the automatic response to threat (Bloom & Farragher, 2011). Many trauma survivors manage strong affect by dissociation defensives, or attempt to self-sooth through self-harming reenactments of past trauma in self-destructive ways (Bloom & Frarragher, 2011; Brown, 2006; Linehan, 1993). Cumulative trauma develops into relational difficulties due to poor modeling of interpersonal skills during childhood (Anda et al., 2005; Pearlman & Courtois, 2005) Traumatic bonding to harmful caregivers leads to a distorted cognition of self-worth and belief that one is unlovable and deserving of harm (Bloom, 1997; Courtois, 2004). Often, poor parenting leads to parentification of the child; the child develops into an adult with the need to be needed and thus provides care to others while remaining dependent on those they care for (Courtois, 2004).

Traumatic experiences are encoded into fear structures of the brain, and trauma survivors have experienced a confirmation of their worst fears (Van der Kolk, 2007). "People under stress tend to do what they know best rather than what is best" (St.Pierre, Hofinger, & Buerschaper,2008, p. 109) and this unfortunately includes reenacting the trauma they experienced(Trippany, Helm, & Simpson, 2006). This leads to sense of self as unlovable. In adulthood or other relationships and in adulthood, the survivors invite others, consciously and unconsciously, to confirm their fears over and over again. This perpetuates reviticimization of themselves and others, including their own children (Heim & Nemeroff, 2001). This reenactment is often seen as self-sabotaging behavior that frustrates service providers (Bloom & Farrangher, 2011).

Revictimization can involve behaviors that harm themselves and others, and can lead to self-defeating and sabotaging experiences (Linehan, 1993; Pearlman & Courtois, 2005). Survivors place themselves in situations that make them extremely vulnerable and unwittingly lead to reliving the trauma. Flashbacks are also seen as a form reenacting the trauma (Van der Kolk, 2007). Moreover, the strong affect that comes with being a victim may be the only feeling they identify with (Ogawa et al., 1993). Some trauma survivors can become addicted to strong affect and feel unstimulated or even not-alive when they do not feel anxious or hyperaroused, which maybe how they survived a traumatic or adverse experience (Bloom & Farrangher, 2011;Linehan, 1993).

This need for arousal also becomes a way of remembering the experience and communicating the horror they encountered (Heim & Nemeroff, 2001). Unfortunately, for service providers who are unaware these dynamics, these relational patterns become assessed in clients as lack of compliance, poor motivation, or as ways to intentionally punish the service provider. As a result, a clinician can become entangled in re-enacting the trauma by being cold, punitive, or in some instances withdrawing services all together (Bloom & Farrangher, 2010). For the client, this confirms that they are indeed unlovable and undeserving.

Disassociating may also be a useful defense to threats in childhood that may be continued into adulthood (Brown,2006). Disassociation leads to fragmentation and becomes a way to escape reality; this feeds avoidance that perpetuates PTSD symptoms (Brown, 2006; Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). The dissociative process can be retriggered by multiple stimuli and lead to sense helplessness and disintegration. Some clients may enter into dissociative states when contacting institutional settings because of the power the institution

represents or inherently possesses. In response, the client becomes dysregulated and voiceless when attempting to meet their needs or advocate for themselves.

This pattern is often observed by case managers who see their clients return from agencies that provide needed services such as daycare vouchers, without getting the needed services because they could not manage a simple obstacle such as filling out a form or going to a relocated office within the same building. For clients who are already feeling dysregulated, the obstacles become insurmountable and evoke deep helplessness. Understandably, in homeless shelters, clients who have past experiences in placement settings such as foster care, residential, or even homeless shelters find that re-entry into residential setting causes extreme duress that promotes dissociative processing.

Emotional processing. Expounding on the treatment models for emotional dystregulation with specific attention to PTSD and anxiety based pathologies, emotional processing theory was developed by Foa and Kozak (1986) to discuss the systematic fear response. Foa and Kozak used the bioinformational theory of fear developed by Lang (1977, 1979) to conceptualize the fear structures that underlie anxiety disorders and the development of responsive treatment. Fear is posited as part of memory structure with associated stimuli, response, and meaning designed to avoid or escape danger. This, in turn, affects behavioral and physiological responses and elicits set of whole system reaction. Fear response is seen as adaptive when facing a true threat that needs a response in order to survive, but this response can be hijacked by trauma and become easily and excessively used. Foa and Kozak (1986) proposed emotional processing theory as framework for understanding and treating this maladaptive response.

They proposed that in individuals suffering from anxiety disorders such as PTSD, pathological fear structures entail excessive stimuli, response, and meaning components

compared to normal fear structure response in non-traumatized individuals (Foa & Kozak, 1986). The fear structure is maintained by two cognitive dysfunctions that posit that (1)the world is dangerous and (2) the self is totally incompetent. Treatment entails modifying the elements that perpetuate the fear structure. This involves activating the fear structure (Phillips & LeDoux, 1992) to challenge fear elements and integrate those elements with more realistic elements. People who have experienced and survived trauma may come to view the world as extremely dangerous and themselves as incapable of dealing with that chronic stress.

Therefore, the prescribed treatment of exposing trauma victims to activity that elicits this response to correct it is inherently antithetical to the patient's desire for relief from the stimuli. This can result in avoidance of the traumatic memory or activating stimuli that develops and maintains traumatic symptoms, including those associated with PTSD. Emotional processing theory posits the exposure and confrontation of the traumatic memories creates opportunities to disconfirm pathological elements of the fear structure, and in turn, ameliorate the adverse responses (LeDoux, 2000). Foa and Rauch (2004) found, that through prolonged exposure therapy, the reduction in thoughts relating to dangerousness of the world and feelings of incompetence; the reductions in these feelings were further correlated with a decrease in PTSD symptoms.

Emotional processing theory indicates that simple exposure is not enough (Foa & Rauch, 2004). Instead, an optimal level of activation must be present, and under or over engagement can impede progress. The patient must be optimally activated and remain engaged in the exposure process to augment the fear structures. As fear structures are modified, the responses to the stimuli will also decline along with the associated anxiety (Bremner et al., 2008). This treatment

is consistent with the phase oriented trauma treatment in which exposure to the trauma narrative in a safe context leads to habitation and builds resilience.

ACES. One of the largest studies of its kind, The Adverse Childhood Experiences Study, a collaboration between Kaiser Permente and the U.S. Centers for Disease Control and Prevention, conducted an epidemiological study on the cumulative effect of multiple forms of abuse and related stressors on health outcomes over a lifetime (Anda et al., 2005) The sample population consisted of 17,421 adults in San Diego County. The mean age of respondents was 56 years for men and 58 for women, and 73% of the sample were White. Forty five percent were college graduates, and 37% had some college education. Most participants had middle-class backgrounds. Adults in the study were given questionnaires that pertained to the first 18 years of their lives that focused on their exposure to adverse experiences. This included emotional, physical, and sexual abuse, as well as exposure to dysfunctional household environments such as exposure to alcohol and drugs, mental illness, violence, separation or divorce, and criminal activity. They were also asked questions on health history, health and medical related behaviors, and psychosocial issues.

Analysis of the responses and medical data revealed a clear relationship between the ACES score and variety of physical, emotional, and social diseases. The study revealed that people with higher adverse life experience scores were at greater risk for heart and lung disease, diabetes, obesity, and had increased teenage pregnancy rates, divorce rates, depression, suicide attempts, PTSD, substance abuse, school failure, and unemployment. A higher ACES score revealed simultaneous increases in co-morbid conditions with disturbances in mental health, physical health, risky sexual behavior, interpersonal violence, and substance abuse. People exposed to higher rates of childhood adversity had a higher probability of requiring services of

public systems including special education, child protective services, mental health service, and criminal justice services. The ACES study was done on with population with higher socio-economic status and therefore the results of the study are more likely to have even broader implications for people experiencing poverty. The large sample size and the revealed association between trauma and health outcomes provide significant empirical support for integrated trauma, neuro, and relational studies.

In order to see if the prevalence of ACES was common in random sample, the CDC (2011) surveyed over 26,000 adults in five states, using the questionnaire from the ACE module portion of the original study . The responses revealed that 59% of the population had at least one ACE score, and 9% of the population had five or more ACE. Respondents with the lowest education levels were more likely to report five or more ACE, and those with less than high school education, compared to those with high school education, had higher instances of physical abuse, incarcerated family members, and separation and divorce in the family. With regard to childhood abuse, 25% reported verbal abuse, 15% reported physical abuse, and 12% sexual abuse, with significantly more women reporting sexual abuse. Lastly, compared to other ethnic groups, Hispanic and Black respondents were less likely to report zero ACE. This study further validated the findings of the original study and further confirms that individuals living in poverty, who are disproportionally from minority groups and women, continue to be the most vulnerable and continue to be victimized.

Moreover, a longitudinal study of over 1000 participants, starting at age 3 with follow up assessments until age 32, assessed how exposure to adverse psychosocial exposures, socioeconomic disadvantage, abuse, and social isolation effected stress related health systems such as the nervous, immune, endocrine, and metabolic systems (Danese et al, 2009). It also

assessed for how ACE effected major depression, inflammation levels, risky clustering of biomarkers such has weight, blood pressure, and cholesterol. Results revealed that children who are maltreated and socially isolated were at greater risk of becoming depressed and of the cohort case samples experiencing adverse childhood experiences, 31% had depression, 13% elevated inflammation, and 32% metabolic risk factors.

The study also revealed that as the ACE increased the number of age-related disease risks at age 32 also increased in dose-response fashion. This study along, with the other mentioned ACES study, highlights the relationship between stress, trauma, development, and health. Thus, service providers cannot make assumptions about how clients came to develop pathogenic symptoms of coping without understanding the background of the client and how past and current stressors influence their current adaptation . However, understanding how individuals are affected by stress and trauma needs to be augmented with insight on how the same stress effect groups and organizations.

Organizational stress. The organizational response to understanding the dynamics of trauma and its residual effects is defined as being trauma-informed. Sandra Bloom (1997), a pioneer and national expert in organizational stress and trauma and the founder of the Sanctuary Model, an evidence supported systems trauma informed systems approach for service delivery, discussed the state of service delivery in human and social services. Through a group understanding stress response, the trauma-informed model proposes a way to radically shift existing treatment models by changing organizational culture so that the organization itself is healthy and adaptive (Bloom & Farrangher, 2011). This entails being responsive to service providers, who often are trauma survivors themselves, or are frontline workers who are exposed to extreme duress (Bride, 2007; Craig & Sprang, 2010; Saakvitne, 2002). In turn, clients who are

experiencing their own response to stress walk into a system that is insightful about its own dynamics and is able to respond to their needs.

Trauma-informed models, such as the Sanctuary Model, do not separate the organizational culture and direct services. Organizations are seen as living organisms, as opposed to a machine, in which there are dependent and interrelated elements that interact with one another . Bloom and Farrangher (2011) discussed the state of human services and the mode in which services are delivered and provide extensive framework, described below, on understanding how organizational stress parallels traumatic stress responses in larger context. Organizations are seen as complex and the staff that provide the services are as critical as the clients. Human service providers must often manage clients' distressing emotions of fear, shame, guilt, and anger while trying simultaneously manage their own emotions (Criag & Sprang, 2010; Cunningham, 2003). They need a model to help manage and contain their own affect so they can become safe place for clients to process their dysregulation.

The stress response to group entails an understanding of how individuals band and form groups and create systems to promote survival. Part of the adaptive and attachment response to threat is to also "tend be friend" and organize into groups to increase power (Bloom & Farrangher, 2011, pp. 137). Bloom and Farrangher (2011) further state that under stress, like individuals, groups become more focused and authoritarian, and less deference is given to complex processing. They describe a process in which a leader emerges in a group process, and group cohesion and allegiance becomes part of group culture and process. Although good for short-term survival, continued states of crisis parallel the same response patterns of hyperarousal, disassociation, and reenactment seen in individual responses to traumatic stress, but on a much larger scale. Group leaders can become dictators who make decisions under the guise of

managing them, unilaterally and impulsively, stating it is good for the group, and create fractions internally because they favor those who support them. If there is dissent, leaders assert more control and these patterns create group norm and culture.

Bloom and Farrangher (2011) elaborate on the crisis process by sharing that as crisis weans, so does control, but group culture is set and higher complex processing is not valued and adaptive positive changes are not implemented as part of the growth. Furthermore, as with human dissociative process, groups also tend to forget or disavow crisis periods, and being ahistorical means that there will be reenactments, just as there are in human responses. Unfortunately, this pattern of functioning does not promote growth or useful functioning, and creates disturbances in service delivery. This organizational stress is further exasperated by lack of funding, personnel shortage, high turnover rates, attitudes of other workers, and lack of connection. This leads to emotional exhaustion in which providers cannot give of themselves and studies reveal that there is substantially more mental distress in health and human services compared to other occupational groups. Service providers for homeless services in rural areas are extremely stretched, and with limited finical support are in active states of crisis while attempting to manage people and system that are in crisis (GAO, 2004; First & Rife, Toomey, 1994).

Bloom and Farrangher (2011) proposed a paradigm shift in how services are delivered and proposed a framework in which human behavior was viewed from an injury model in which human systems are not thought of as sick or bad, but as injured. This means that reductionistic treatments that isolate pathology fall short and lead to the fragmented treatment system that service providers and clients find inadequate. For example, the same people who are homeless continuously loop through the institution that services them and their children such as jail,

prisons, and mental health institutions because treatment is not holistic. However, in a model that looks at the system and people as injured, there is opportunity to cause change in interpersonal and social context, because the model inherently assumes a relationship exists. Recovery and rehabilitation are a mutual and long-term process and understands that lifelong enduring patterns require patience and insight. This model rejects the "sickness/badness dichotomy…to a very different question of 'what *happened* to you'" (Bloom & Farrangher, 2011, p. 136). By providing holistic treatment in one setting, the need to continually cycle through institutions is lessened.

As with trauma victims, service providers must be aware of and name their pattern of functioning in their organizational context. This often means getting insight from all levels of the organization and having an awareness of the parallel process described above. This insight can create a system that responds to organizational conflict and stress in a fair, conscious, and dignified manner that promotes morale. This helps to combats burn out and is responsive to vicarious trauma and general fatigue (Bride 2007; Craig & Sprag; 2010; Pearlman & Courtois, 2005) . Such a model builds a system that is safe for staff, while simultaneously providing safety for clients.

Trauma-informed models have been getting substantial attention, and large intuitions have been implementing these values in their treatment models (Bloom, 1997; Bussey, 2008; Cohen,& Mannarino,2008; Elliott et at., 2005; Jensen-Doss, Cusak, & Frizzetti, 2009; Pluck et al., 2011) . As mentioned, there is a trauma informed model and tool-kit for shelters that outlines how shelter systems can become organizationally trauma informed and build safety in the structure (Soares, Konnath, Clervil & Bassuk, 2009). However, the tool-kit does not discuss how to work with the individual responses to trauma, and instead suggests contracting individual service providers to give this intervention. Unfortunately, rural areas have limited resources and

cannot refer services. The treatment of traumatic symptoms will be outlined below, and principles from the treatment process will be incorporated in the curriculum for case managers.

Treatment of trauma. The primary format for addressing the effects of trauma on an individual basis is through the treatment of PTSD symptoms. Babette Rothschild, a prominent social worker in the field of trauma, details treatment for trauma in her seminal book *The Body Remembers* (2000). Rothschild advocated for a phase-oriented treatment that emphasizes establishing safety and alleviating symptoms experienced when reliving the traumatic event in thoughts, feelings, and actions. She described how the traumatic experience and memory is encoded into the brain and processed somatically; this is a key factor in the exacerbation of symptoms. Influenced by neuropsychology and attachment theory, Rothschild explaind the mind-body connection and created a template for treatment to address the pattern of avoidance and arousal. The goal of treatment is to unite implicit and explicit traumatic memories into a comprehensive narrative, to eliminate or tolerate the hype- arousal and intrusive symptoms associated with the memories, and to situate the traumatic event in the past.

Rothschild (2000) provided a stern warning to do no harm and to establish safety before engaging in direct treatment of trauma symptoms. It may be retrauamatizing for clients to move at a treatment pace that is faster than what they are able to process. The assessment phase of treatment establishes what type of trauma the client has experienced, and based on that assessment treatment needs will differ. Rothschild also encouraged clinicians to be aware the attachment patterns that the client has developed, as these may be influenced by the trauma. The social worker must be prepared to work through periods of attunement and misstatement.

Boundary setting is also a vital component of treatment, especially for individuals who have experienced complex trauma and have trouble in interpersonal relationships. Rothschild

(2000) encouraged a flexible therapeutic relationship that can tolerate and navigate through different styles of relating and shifting affective states. Depending on the vulnerably of the client, safety can be further established by removing triggers of flashback in session, and by establishing or increasing resources that she classified as functional, physical, psychological, interpersonal and spiritual.

It is important to note that at this level mezzo and macro level, interventions may be necessary if resources are not available. Herman (1992) rejected a neutral clinical stance and asserted that clinicians must be moral witnesses and affirm the patient's reality. If safe systems do not exist, helpers must engage in social and political activism so that history is transformed instead of repeated. Trauma-sensitive and trauma-informed systems become a culturally safe environment for individual work to take place.

Because trauma work can be exhausting to a person's system, identifying healthy distractions and tangible safe places can help provide respite from symptoms. If one is not able to have a physical safe place, Rothschild (2000) encouraged processing a 'good enough space' as part of cognitive restructuring. If everything is tainted by the trauma, the client needs help finding meaning and safety in creative ways. After creating a safe space, awareness of somatic symptoms and their connection to affect is taught, processed, and modeled. This helps individuals understand their subjective states of relaxation, arousal, and hype-arousal so they can learn to tolerate and master their anxious states.

In session, the clinician will help stagger the sates of exposure and arousal to help the treatment process proceed at reduced level of arousal so treatment is done in a non-traumatizing and safe manner. A body diary can help the client keep track of past and current triggers, and also help process negative and positive body memories and can help ground the client during

flashbacks. Lastly, Rothschild (2000) has the individual address the trauma narrative by naming the trauma, outlining the traumatic experience, and filling in the details of the experience. Piecing the traumatic memory involves confronting horrific events and also navigating through feelings of construction and intrusion. The goal is not simple forensic fact finding, but making meaning of the experience and facing the moral and ethical situations that facilitated the trauma. This process often calls the individual to examine the relationships and systems they interact with.

As this process is fully realized, the individual can reclaim traumatic memories and feel hope. Trauma is no longer central to identity and the tools gained from processing the trauma can empower survivors to face uncertainty. Trauma resolution is never final or complete, but recovery is possible.

Empirical support for trauma theory and treatment. Trauma and traumatic responses are multidimensional, and there is a wide range of outcomes in how people respond to trauma. The prevalence of traumatic experiences, defined as single or multiple incidents in clinical and non-clinical samples, ranges from 33% to 81% (Bussey, 2008; Courtois & Gold, 2009; Cunningham, 2004). Regarding individual perception, processing, and retrieval of traumatic of memories, numerous studies in neuropsychiatry reveal through brain imaging studies that patients with PTSD have significant limbic involvement (Van der Kolk, 2007). They have decreased hippocampus volume and excessive activation of the amygdala-related structures that process emotions (Herman, Cullinan, 1997; LeDoux, 2000; Phillips & LeDoux, 1992). The major tenet of trauma theory is that trauma is a physiological experience and effects brain processing (Van der Kolk, 2002). Biological evidence must be part of the empirical data that supports this tenet.

However, it is important to note that not all people who experience trauma develop PTSD, and there is not a linear causal relationship between traumatic experience and PTSD (Bryant 2005; Van der Kolk, McFarlane, & Weisaeth, 1996; Van der Hart, 2007). Trauma does not equally impact the psyche. The individual's subjective responses to trauma affect psychological coping and can be moderated by personal characteristic and psychosocial development (Agaibi & Wilson, 2005). Attachment theory, as well as risk-resiliency framework, have addressed these mediating factors (Agaibi, 2005; Shore & Shore, 2008; Williams, 2006).

As mentioned, attachment theory asserts that hard wiring of emotions and regulatory functions are influenced by interaction between the infant and caregiver (Fongay, 2001). Healthy interactions between the dyad enhance synaptic connection in the brain, and can lead to secure attachment (Shore & Shore, 2008). The need to attach is inherent even if it is to an abusive caregiver and insecure attachments are often seen in victims of complex trauma (Courtois, 2004). They experience internal and external stimuli in maladaptive ways and struggle to self-regulate.

On the other hand, the risk and resilience framework redirect the discourse from the psychosocial vulnerabilities of traumatized populations and instead aim to identify strengths in surviving populations. Agaibi and Wilson (2005) reviewed the literature on trauma, PTSD, and resilience, and identified factors that interact together to produce resilience. These factors include: perceived locus of control, self-disclosure of trauma to others, sense of group identity and positive self-perception, altruistic behavior, capacity to find meaning, and connection bonding. These findings are consistent with the treatment goals of trauma theory and the treatment process. In particular, disclosure of the trauma and finding meaning and connection are the central tenets of trauma theory.

Because trauma research has been growing, there are specific evidence-based treatment modalities and frameworks for different target populations. The sanctuary model, was originally intended for residential treatment settings for children and youth (Bloom, 1997). It recognizes that children and adults entering residential programs often have trauma as part of their history, and creates a systematic template for organizational transformation. It also has curriculum for interventions. Because it is a total systems change, it requires consultation with the sanctuary faculty and is costly to implement.

Trauma-focused cognitive behavioral therapy (Cohen & Mannarino, 2008; Cohen, Mannarino, & Deblinger, 2006; Deblinger et al, 2011; Feather & Ronan, 2009) is also an evidence-supported treatment model that targets children who have experienced grief and trauma and is endorsed by Substance Abuse and Mental Health Services Administration (SAMHSA). It also targets parents and provides psycho-education and stress management skills to help clients' parents' process the traumatic events as well. The National Child Traumatic Stress Network (NCTSN) is a group of treatment and research centers funded by Center for Mental Services that aims to find best practice models. It has created the *Child Welfare Trauma Training Toolkit* to help identify trauma-informed child welfare practice guidelines (Ko et al., 2008). Children entering Child Protective Services or foster care by definition have incidents of trauma in their narrative and the toolkit is a useful guide to raise consciousness about the role of trauma in their lives.

Risking Connection is a comprehensive trauma curriculum for adult survivors of childhood abuse and is also endorsed by SAMSHA (Courtois & Gold, 2008). The *Trauma and Recovery Empowerment Model* (Fallot & Harris, 2002) and *Trauma Affect Regulation: Guide for Education and Therapy* (Frisman, et al., 2008) are treatment and education models that address

impact of trauma in group settings. These specific treatment modalities and tools provide evidence supported practice treatments for specific populations, and help bring academic rigor to trauma theory. The review of trauma and homeless studies reveals the past and current state of each area and reveals the inherent connection. It indicates that individuals with trauma can be found in homeless shelters, and service providers need to understand and respond to their needs in a more comprehensive manner so they can disrupt the cycle of trauma and build resilience.

Community-Based Participatory Research That Informed Curriculum

Because there was sparse data on understanding the needs of transitionally homeless women and families, particularly in rural regions, this author (who was also a program manager of the agency site) became a co-investigator in participatory research at a transitional shelter in Northcentral Pennsylvania. The study used community based participatory research process (CBPR) in which clinicians, case managers, researchers, residents of the shelter, and other community service providers comprised of the research team. CBPR model was used because it is a process that works *with* as opposed to in a community to impact change and build knowledge (Israel et al. 1998). Clients are not research objects or subjects but partners in a process that promotes co-learning and capacity building. The process builds on strengths and uses an ecological framework that involves whole systems through an iterative process. The goals are tangible outcomes that aim to be long-term and sustainable. It is particularly a good fit with social work values and practices and in the CBPR process there is an intersection of intervention, advocacy, social justice, and policy change. In this case, the voices of the women were missing in past research as well as a nuanced understanding of what they perceived as areas of need in their particular circumstance.

Prior to the CBPR research, the staff of the agency met with health and policy professor of local university, who was also a co-investigator in the CBPR study, and discussed the contextual issues that contribute to homelessness within their community using the PRECDE-PROCEED model, (Green & Krueter, 1991) . This involved a discussion and examination of the economic, social, ecological, and physical factors that influence client perception of self-sufficiency according to service providers. Policy and environmental factors that influence outcomes and implementation were discussed as part of the process. Through the use of PRECEDE-PROCEED model the staff were able to better articulate and understand the outcomes they needed. However, the perspective of the clients was still missing . To better understand the needs of the clients and validate the assessment of the PROCEDE-PRECEDE process, there was need for continued research and to bridge that gap, the CBPR study was conducted.

The CBPR research team met over a 6-month period, fall 2011 to spring 2012. The initial meetings occurred over 4 consecutive weeks that lasted approximately two hours and additional individual interviews were conducted over the next 6-month period. The aim of the research was to engage in a process to develop and implement a shared research mission, decision-making structure, and indentify best process to enhance and sustain meaningful continuum of care that leads to self-sufficiency. Each meeting was recorded with consent and transcribed. Line by coding was done with the transcripts and the combined individual coding was collated into large data set that was analyzed for themes. The team discussed the coding and gleamed four themes. To determine if group discussions reflected individual experiences, structured individual interviews were conducted.

The themes that emerged from the process included: (a) health and human services, (b) education (c) career/employment, (d) parenting. Each theme was further broken down into how it presented as internal and external barriers. Consistent with CBPR and social work values, there was also an analysis of the strength, resilience, and capacity demonstrated in each theme. With regards to issues related to health and human services the women expressed these external barriers:

- Not knowing and being unable to access health and human services;
- Duplication and fragmentation of services "getting the run around";
- Not taking advantage of internal resources;
- Domestic violence;
- Criminal backgrounds and poor credit histories (repeated theme); and
- Lack of affordable housing.

The women describe feeling trapped by their past and mistakes and having repeated unsuccessful attempts to ameliorate their problems. Internal barriers that compounded these issues were:

- Poor time management skills;
- Mental health issues;
- Burnout; and
- Lack of self-efficacy.

The study combined the themes of education and employment because the barriers were cyclical and mutually dependent. It also highlighted that the residents of the shelter had an

understanding of the relationship between education and employment and wanted to have meaningful careers that were supported by appropriate education. The external barriers included:

- Lack of information on how to apply for and get financial assistance;
- Desire to attend school but it seems like a luxury item in the daily struggle to survive;
- Prior student loans or delinquent financial status;
- Loss of funding to programs that help with education;
- Low-paying jobs; and
- Need for access to community resources for career development.

An attempt to secure and maintain employment while in crisis is extremely distressing and this is further complicated by criminal histories that were reported to be apart of their internal barriers. This led to additional internal barriers which were high stress and management of hectic schedules. The women and children came to the shelter with trauma and adverse experiences and even after a period of external stability, their attempts at upward mobility are sabotaged by internal distressed states or lack of skills in managing multiple systems.

The sample of women at this transitional shelter reflected the national sample in which a majority of them were single mothers with children. Even the single participants were parents of adult children or parents that did not have custody of their children. As a result, it was not surprising that parenting was a salient theme. The external barriers related to parenting were:

- Reliable and affordable daycare;
- Transportation;
- Parenting skills;
- Activities for children and education development; and

- Cultural differences in parenting styles.

They described being caught in a trap in which they needed daycare to be employed but daycare vouchers were only given once employment was secured and first pay stub are presented. They felt trapped in leaving their children with unreliable or dangerous caregivers while they attempted to get work and vouchers. Again, these external barriers exasperated their internal struggles. The internal struggles they discussed were:

- Being a single parent;
- Having poor parental role models;
- High stress; and
- Poor communication and parenting of their own children.

Despite these tremendous internal and external barriers, the women were able to participate in the research process and felt proud that they could be a part of a lasting change process. They were able to discuss their strengths and practitioners , staff, and community providers were able to see and understand their capacity. It was apparent the women were able to be resource and natural supports for each other. They were able normalize stress, discuss how they overcome their hurdles, and continue to have hope and aspirations despite bleak circumstances. They also mentioned that the transitional shelter was a safe place for their children and they viewed the staff and internal programming as allies.

Part of CBPR process was to influence policy and changes as a part of the research process. There were many program changes that were done as part of the research findings, but the changes were particular to the site and resources. The study further validated a need for case managers to be equipped to address the internal and external barriers of each theme. Adverse life experiences and traumatic narratives were described as both internal and external barrier of each

theme. Moreover, issues of domestic violence and substance abuse were apart of most of the women's background, again reflecting national data. The aim of this study's curriculum is to address the internal and external barriers addressed in each theme in a trauma-informed manner. The curriculum will be used by case managers to help clients address the barriers in a process-oriented manner that acknowledges and addresses current and past trauma. The method of developing the curriculum is described below.

Chapter 2: Method

Curriculum Development

A curriculum for case mangers that provide services to homeless women and families incorporates the phase oriented trauma intervention models. This will be done by establishing safety through a comprehensive assessment process. This entails building trust and working at a pace that is sensitive to client need and desire. The assessment phase will use reliable and validated tools that screen for trauma and are culturally sensitive. The assessment tools must also be accessible financially to fiscally strained agencies and also easy to use by all levels of professionals. Process oriented principles from stages of change model (Proschaska & Norcross, 2001) and motivational interviewing (Miller & Rollnick, 2013) will be incorporated as part of the engagement process. After the assessment and goals have been set, the modules that address specific areas of need can be used to help address internal and external barriers.

The modules aim to increase self-sufficiency by incorporating factors that promote resilience using principles of self-regulation from attachment frameworks, exposure practices from emotional processing theory, and principles of self-disclosure. Together, these frameworks contribute to a trauma theory that can increase locus of control, build capacity and find meaning, increase communal connection, and promote altruism. These traits promote strength to negotiate the needs in larger contexts and overcome external barriers. The curriculum will focus on these areas:

- Accessing health and human services;
- Education;

- Parenting;
- Employment;
- Substance abuse
- Domestic violence; and
- Emotional regulation and attunement.

This curriculum will be implemented by case managers who will indentify the individual needs of each client in conjunction with internal and external barriers, practicing and role-playing how to work through each need. These exercises will help build regulation skills, and the exposure to past trauma in a safe setting will help restructure the associated fear. In turn, this will empower and build capacity for future skills and increase connection building on the factors that promote resiliency as outlined by Agaibi and Wilson (2005). The purpose of the curriculum is to disrupt the cycle of homelessness and give relief to clients through the implementation of tangible skills by trained service providers.

Lastly, the content of the curriculum and the attitude of case managers will be evaluated. To test for expert validity, the content of the curriculum will be evaluated in a focus group interview with case managers and service providers of homeless populations that have seen the curriculum. The attitudes of the case managers will also be assessed by adapting the Evidence-Based Practice Attitude Scale (EBPAS) developed and validated by Aarons (2004). The EBPAS assesses provider attitudes towards adoption of new interventions in the following 4 domains:

1. Inherent appeal of the innovation or tool
2. Openness to change (including organizations openness to change)
3. Divergence from current practice
4. If it is required to adopt the intervention

These evaluation components address content and implementation process. However, the aim of this study is to develop the curriculum content; issues of implementation are topics for future work.

That said, actual implementation is the true purpose of this curriculum. Too often, frontline workers are directed towards descriptive workbooks—or, as one administrator shared with the author, to a website on becoming trauma-informed. Although such resources are welcome if they are useful, practice-informed research and intervention, such as this curriculum, urgently need to be disseminated in a strategic and rigorous way. This will entail planning a controlled pilot study in which the effectiveness of this curriculum is evaluated. Issues to be considered in future study include assessment of buy-in by shelter agency leadership as well as by case managers; before-and-after evaluation of case managers' content and process knowledge; and assessment of how well self-care strategies are implemented. Once refined on the basis of the pilot study, implementation may naturally lead to a trauma-informed orientation process for case managers.

Individual client outcomes or the meeting of stated goals can be used as measurements to evaluate the effectiveness of the individual sections of the curriculum. Lastly, future implementation will entail reworking the curriculum into first-person language so that it is more accessible and relatable to the readers. Consistent with social-work values, this curriculum is informed by practice and research and infused with the hope of meeting the needs of a growing marginalized group by equipping frontline social workers to practice in a trauma-informed manner. The content of the curriculum is detailed in the subsequent section.

Chapter 3: Curriculum

Introduction

Social service providers who work with transitionally homeless women in rural and suburban regions are confronting limited resources and rapidly growing demand for their services (AHAR, 2010). At the same time, financial support for services has not increased, and funders are placing a strong emphasis on outcomes while asking for services to be delivered in a trauma-informed manner (Olivet, Paquette, Hanson, & Bassuk, 2010). The purpose of this curriculum is to give case managers working with transitionally homeless women a tool for providing trauma-informed services in a cost-effective and responsive manner.

This curriculum will support case managers as they provide services to homeless women and homeless women with children in a manner that is sensitive to the particular experiences that result from being homeless; such a model is considered *trauma-informed* (Harris & Fallot, 2001). Homeless individuals face tremendous physical, emotional, and psychological challenges, and are in active states of crisis. Being purposeful about how service is delivered and mindful of the extreme stress that homelessness brings is a key element of being trauma-informed. Researchers as well as service providers define trauma as experiencing or perceiving an event as life-threatening and overwhelming (Bloom, 1997; Courtois 2004; Foa., Keane, Friedman, & Cohen, 2000). This experience is coupled with the feelings of intense fear and helpless that accompany a loss of control (Herman, 1992). These sorts of stressful events produce biological and emotional responses that have serious residual consequences for survivors, including homeless women.

Homeless women and their children, then, come to shelters in vulnerable states and need strategic services delivered in a way that is sensitive to their experiences; they also need support in overcoming barriers. Many service providers mistakenly assume that being in a shelter provides an immediate sense of physical and emotional safety compared to the unstable housing the women most recently experienced. However, many women and children stay in prolonged fearful and anxious states after entering a shelter; they are unable to begin feeling safe or at ease for long periods following their entry. Unaware of the need for an extended period of adjustment, many case managers design service plans and interventions that are premature and poorly sequenced and that create additional stress for the already overwhelmed women and children.

Aiming to please case managers or fearing that their housing placement is conditional upon compliance with intervention services, women often attempt to meet the goals of their service plan, even in the absence of the necessary internal or external supports they need to succeed; this commonly results in self-sabotage. Their struggles with the intervention program place them in even more precarious situations and undermine their relationships with their case managers and the shelter staff. As this situation deteriorates, the place that is meant to be a safe haven for them becomes increasingly stressful. As a result, many of the most vulnerable women are unable to maintain their stay in the shelter. This places the women and their children at more risk, as they are labeled as non-compliant—or, worse yet, may never seek services again.

The aim of this curriculum is to avoid such traps by presenting a service plan that systematically incorporates trauma-informed protocols that are responsive to the needs of survivors. The implementation of such a curriculum can ensure that, upon contact with the shelter system or any transitional housing, women have meaningful interactions that help them feel safe, grow, and connect with the community and the resources they need.

Background

Homeless women and trauma.

Homelessness and its causes. Homeless individuals are described as visibly marginalized because of their obvious lack of residence (Lee, Tyler, Wright, 2010). However, many people live in jeopardized housing status or are face an imminent risk of being homeless. Some live "doubled up" or in substandard housing, in situations that frequently become untenable. How they come to be homeless can vary, from a single catastrophic event such as a flood or unexpected illness, to living in a persistent state of crisis with poor economic resources (AHAR, 2010). In most cases, homelessness is caused by some combination of personal and social vulnerabilities, poor support, and bad luck.

Female and rural homelessness. A large proportion of homeless women—77%—represent homeless families (AHAR, 2010). In general, homeless individuals and families experience higher rates of victimization, mental health disorders, substance abuse issues, and insufficient economic resources (Elliott & Krvo, 1991; Hamilton, Poza, & Washington, 2011; SAMHSA 2011). These statics are even more pronounced when the homeless individual is female (Bassuk et al., 1997).

Homelessness in rural and suburban regions has been increasing, and the 2010 Annual Homeless Assessment Report (AHAR) revealed that since 2007, the use of homeless programs in rural and suburban areas has increased by 57%. Increased rates of poverty and unemployment in rural areas contribute to homelessness, and female-headed families are most vulnerable. There is a significant lag in income and educational levels for women, and young single women and mothers with children comprise a large portion of the homeless population in these regions in particular (Mosley & Miller). Studies reveal that family violence and dissolution of relationships

are the most cited causes for becoming homeless (First, Rife, & Toomey, 1994). When this is accompanied with underemployment or informal work, the ability to be upwardly mobile or self-sufficient without additional support is nearly nonexistent.

Problems homeless women face. Homeless women and mothers often have histories of childhood abuse and/or drug and alcohol abuse and have fewer social supports (Hopper, Bassuk, & Olivet, 2010). Researchers who have explored the factors that increase the likelihood of a woman becoming homeless found that foster care placement, family history of violence, and low social supports were predictors of homelessness (Bassuk et al., 1996). Regarding psychological distress or mental health, up to 92% of homeless women reported experiences of severe physical or abuse over a lifetime, with two thirds reporting histories of domestic violence (Morrisey, Jackson, & Ellis, 2005). This translates to high rates of posttraumatic stress disorder and increased dependence on drugs and alcohol (SAMHSA, 2011).

Homeless children. Homeless children are exposed to traumatic and adverse life experiences that affect their overall development. Homeless children have multiple health problems, poor nutrition, developmental delays, anxiety and depression, and behavioral problems, and they under achieve educationally (Rafferty & Shinn, 1991). Homeless children also experience multiple moves, are separated from families, and often witness violence (AHAR 2010). These vulnerabilities are compounded by their mother's personal trauma history and current stressed state.

The problems homeless children face reveal the depth of their needs, and demonstrate the need for shelters to provide more than just living units. In order to further understand the effect of the past and compounded stress, case managers need to understand how both "routine" stress and traumatic stress affect functioning during childhood and how these experiences influence

their future attempts at stabilization. This understanding can help disrupt the cycle of trauma and provide a sustainable pathway to becoming self-sufficient..

When bad things happen to good people: Understanding stress response.

To understand and treat the effects of trauma, it is important to recognize the impact trauma has on the brain, on physical and psychological development, and on how traumatized people relate to others. This includes understanding a common stress response that induces hypervigilance or dissociative reactions (McEwen & Gianaros, 2011). Understanding the physiology of this process helps explain what can appear to be chaotic or unpredictable behavior displayed by clients with trauma histories, such as homeless women (Bloom & Farragher, 2011). When homeless women come to shelters for services they are in an extremely stressful situations; their lives and the lives of their children are in danger. Most of these women have histories of severe trauma that can, perhaps ironically, make being homeless seem a relatively minor issue to them.

Most service providers initially understand the stress level homeless women have experienced, but may soon lose patience. In particular, they become frustrated when the women do not express gratitude for services or are not compliant with rules. Service providers become especially incensed when they perceive the women as demanding, hostile, or, worse yet, manipulative, or as what they label “takers.” Within this dynamic, the women receiving services are perceived to be “service shopping”; they are thought to be there to get what they can without doing much, or to be approaching their responsibilities with what the provider feels are “bad attitudes.” As this situation persists, the service providers come to resent the clients they serve, and clients perceive this hostility and either escalate their behavior or become withdrawn.

Unfortunately, this dynamic is common. It ends up hurting the very people it aims to help; it also disillusions service providers and creates an “us versus them” mentality that

demeans both the clients and service providers. By understanding why the women behave the way they do, service providers can look beyond the "bad attitude" or the "taking behavior" they consider character deficits. The women's behavior makes sense when the context of their past history and current distress is revealed and considered. When the underlying causes of these behaviors are exposed, service providers are better able to practice empathy. They can use this empathy to create an atmosphere and service plans that are cognizant of this dynamic between homeless women and providers. The ability to empathize begins with understanding what stress does to the brain and body, and how stress shapes the way people relate to one another. This also includes understanding how stress response looks in developing children, as well as how it manifests in adults who were raised in stress-filled environments.

Adaptive coping. The human brain plays a key role in mediating ongoing stress by facilitating adaptive coping through regulation of physical and emotional experiences (Schore, 2011). Traumatic or adverse experiences are interpreted as stress by the brain and body. When an individual is faced with a threatening situation, the nervous, metabolic, cardiovascular, and immune systems engage in a fear response commonly known as the *fight or flight response* (McEwen & Ginanros, 2011). These responses increase heart rate, blood pressure, and cell metabolism to help the body prepare for action. The structures of the brain responsible for processing emotion, memory, and hormone regulation are also activated (Bremner, Elzinga, Schmal, & Vermette, 2003). This is why traumatic memories can become encoded into the memory of survivors in sensory formats such as sight, smell, or taste. Higher brain processes such as complex reasoning are curtailed and replaced with "adaptive focused processing," resulting in tightly focused attention (Morilak et al., 2005). This focused attention, in the form of hypervigilance, makes the individual aware of very specific factors in the environment that either

support or threaten survival. Once the event has passed, the hyperactivation ends and the brain tries to use nonsensory areas, such as verbal processing structures, to help make meaning of what happened.

This stress response can be positive and adaptive when it is short-lived and when there are buffers in the environment that help repair the damage or help the individual gain mastery over the challenge or distressing event (Bloom & Farragher, 2011). But the stress response can become toxic when it is unrelenting and chronic, which is often the case with homeless women. When stress persists over time, the body does not have the opportunity to deactivate, rest, and repair. The long-term effect of this stress response are wear and tear on the body that can result in higher incidence of illness and premature death (Danese & McEwen, 2011).

Adverse life experiences such as child abuse, neglect, parental separation or divorce, mental illness, and exposure to a household with violence, alcohol, drugs, and criminal activity create a simultaneous increase in comorbid health conditions such as heart disease, diabetes, and depression (Anda et al., 2005). Moreover, adverse experiences accelerate aging in the cells because of the constant stress response. So indeed, prolonged stress can kill (Danese & McEwen, 2012). The risk factors correlated with homelessness are also the very same ones that result from becoming homeless. Thus, understanding the process and long-term effect of stress and trauma is critical to managing and minimizing the severity of its impact.

Another response to extreme stress is disassociation. Disassociation, or shock response, is a response to fear by the central nervous system. Dissociation occurs when one detaches oneself mentally from an immediate experience to temporarily minimize the impact of overwhelming stress (Bloom & Farragher, 2011). Disassociation, by definition, distances the person from what is happening. It can be as minor as daydreaming or being in a trance, or as severe as losing

consciousness or even "leaving the body." This ability to lie to oneself to deny a horror can trick the body into surviving by minimizing overwhelming pain.

If someone uses dissociation often, that person can remain unaware of distressing emotions or feelings that are related to the past or its traumatic events (Courtois & Ford, 2013). Dissociative individuals may also feel as if they have separate parts of themselves that they really do not understand or have access to; sometimes they may feel like they have they have split personalities. To a case manager dealing with a dissociated individual, it may seem that she has separate personalities and may confuse the manager with inconsistencies. This can make both the case manager and the client feel crazy or at least extremely frustrated. Case managers must be aware of this and observe this pattern of relating in order to be helpful to the client. It is important to understand that dissociation-induced inconsistent behaviors are not intended to be bad or manipulative, but are part of a learned stress response that has helped them survive.

It is also important to note that dissociative coping can be triggered when trauma survivors come into contact with institutional settings because of the inherent power the institution represents, or because of past traumatic association with the setting. This includes the shelter system itself because of its similarity to foster care and other residential care settings. Instead of feeling safe, some homeless women become dysregulated and voiceless in the shelter setting, and struggle to advocate for themselves. They may come off as hostile because they are grappling with feelings of deep helplessness. They may also seem withdrawn, absent, or simply unresponsive. This behavior can be read as rude and ungrateful, which can trigger hostility in service providers. Often, though, the women are unaware they are fragmented or dissociative, and can only describe feeling discomfort that they may attribute to the shelter or case manager.

This potential gap between provider and client provides a compelling rationale for the value of safety-building and strong assessment.

Adjustment following crisis. This stress response is what is typically happening to homeless women and their children. When homeless women and their children arrive for services, their stress response system is on high alert, and they are hypervigilant. This means that upon entering the shelter, they are in an active state of defense and are assessing the environment for safety. Thus, while they may seem aware and responsive to the case manager while she is going over paperwork and/or the rules of the agency, they are likely to be more focused on the physical environment: looking for exit doors, checking for other potentially harmful residents, and trying to determine whether the case manager is "safe"; they are not processing the details they are presented with. Sincerity or kindness in the moment will not reduce their defensive coping; there must be a sustained period of feeling safe before they will deactivate their stress response and begin to trust others.

Note also that the hypervigilance is not always obvious, and the client may not be aware of it or the effect it is having on her behavior. The client may appear to be calm, sign the paperwork without objection, and tell you she understands the rules. Internally, however, she may be hypervigilant, and the higher processing skills necessary for reasoning and critical thinking may be secondary to her survival responses. This is an automatic adaptive coping strategy that has ensured her survival in the period immediately prior to entering the shelter; but though the strategy worked for her before, it can quickly become problematic. For example, when the client breaks a rule or asks questions about details that have already been discussed, the case manager should understand that the client is not showing disrespect or trying to assert her will. Far more likely, she is not effectively processing the information. Embarrassment over her

failure to remember or fear that her placement could be jeopardized may make the client less apt to ask for reminders or clarification. As a result, she may try to figure things out on her own and try to manage this new environment on that basis. Sadly, and often, this is interpreted as manipulative behavior when in reality the client is trying to comply. This is an example of how the stress response directly shapes behavior and how the individual tries to relate to others.

When a person experiences cumulative stress, it is as though the body is perpetually prepared to fight. This leads to a dysregulated internal state that is expressed in functional impairments in relations and behavior (Sterling, 2011). Such impairments can variously present as hyperactivity, sleep disturbance, impulsivity, or psychological disturbance. Hypervigilance can also lead to anxious states because traumatic flashbacks or associated feelings can be triggered by neutral or unknown stimuli (Perry, Pollard, Blakely, Baker, & Vigilante, 1995). For some women, for instance, it can take a very long time to be able to sleep through the night at a shelter. Others may sleep for days at the beginning because it is the first time she have felt safe. Still others may appear to be bursting with energy and attempt to meet all their service goals within the first weeks because they feel they will not be safe until they have secured their own residence. These behaviors illustrate the varied ways in which the body and brain try to manage stress and are influenced by their natural or learned response to threats.

Long-term effects of prolonged stress and crisis. Early experiences and interactions influence how the brain develops and inform how an individual perceives the world as safe or unsafe. This explains why certain women continue to maintain poor ways of relating despite receiving services in a trauma-informed manner or having caring and responsive case managers. They have experienced chronic stress for their entire lives and their brain structure has been

impacted. This influences how they relate to others and the world. Here is how this process happens.

Because children are small and vulnerable, threat-filled environments can be damaging to their brain development. A common reaction children have to a threat is crying or vocalizing fear to their caregiver. If these fears are not addressed by a responsive caregiver, a child can experience a range of responses that may include a "freezing" dissociative response in which the child disengages from the outside world and turns inward (Pynoos, Steinberg, & Goenijan, 1997). This can present as a glassy-eyed, disengaged facial expression, as daydreaming, or in some cases as complete loss of consciousness (Perry et al., 1995).

In some instances, children engage in freezing behavior in which they tune out an authority or caregiver (Katz, Sprang, & Cooke, 2012). This often causes an escalation of demand by the caregiver, which makes the child even more anxious. Children can also engage in hypervigilant behavior and become very anxious and sleep-deprived. This in turn may make them irritable throughout the day, or disengaged from classroom activity. This type of behavior is often observed in children living in shelters.

Other children may externalize their stress response by being hyperactive and impulsive. This response to trauma is often diagnosed as ADHD or some other behavior disorder, and is most often seen in young boys: girls tend to internalize stress and use dissociative defenses more than boys do (Perry et al., 1995). When case managers provide services in a trauma-informed manner, they are able to help the mother cope with her environment better so that she can provide security and nurturing reassurance to her own vulnerable children. This provides a buffer against the long-term negative outcomes of living in crisis.

Some mothers are also able to model for their children the skills that help to overcome adversity. Any responsive caregiver, in fact, helps shape the child's perception of self and others by modeling how to manage internal states of stress. A self-regulated caregiver, able to manage her own internal state, can appropriately read the environment and assess danger (Bowlby, 1977; Schore, 2001). Such women know themselves and can react in predictable, safe manner. They are also attuned to what their child needs physically and emotionally. Therefore, when their child cries for help, they know to attend to their child's needs by soothing the child or—if they assess the environment to be dangerous— removing the child from harm's way or by reducing the impact of the threat (Fonagy, 2001). This behavior on the part of a caregiver provides a secure base from which children can explore and develop a healthy perception of themselves and the world.

If a child is raised in chronically stress-filled environment, however, the brain is bathed in stress hormones, and brain architecture is altered (Giedd & Rapoport, 2010). Unrelenting stress communicates to children that there is no one to protect them from harm. Because they are children, they come to believe that this is because they are not lovable or worthy of protecting. There may be no one in the child's life to counter this sad assumption.

Being exposed to constant stress also produces hypersensitivity to threat, and may impair a person's ability to distinguish between a minor threat and a severe one (Bremner, 2003). Such hypersensitivity can be seen in adults and children who seem to explode in anger easily or be set off by very minor things such as a glance or accidental slight. It is often also strongly manifest in the children of homeless women where the mother has a limited ability to self-regulate or manage stress. And even with a caring and capable mother, children may behave in an unpredictable manner because they are unsure of their future.

Past trauma, as well as current trauma or stress, deeply impacts how interactions are processed. Trauma survivors have experiences that confirm their worst fears (Van der Kolk, 2007). As a result, many survivors of trauma perceive themselves as unlovable. Adult survivors often reenact their trauma by inviting others, consciously or unconsciously, to confirm their fears over and over again. Doing this revictimizes them and often their own children. Some trauma survivors can become addicted to strong emotions and may feel fragmented or dead unless they feel anxious or hyperaroused. This need for arousal becomes a way of remembering their experience and of communicating the horror they encountered.

Unfortunately for service providers, these ways of relating can be extremely frustrating and may look like noncompliance or deliberate attempts to punish the service providers. In these cases, service providers can become unwitting parties to the reenactment of the trauma, confirming to the client that they are indeed unlovable and undeserving. This is the trap that must be avoided; a principal aim of this curriculum is to help service providers, and particularly case managers, avoid such an outcome.

That said, experiencing a stressful or traumatic event does not automatically produce the symptoms described. The biological response to threat combines with the meaning the person assigns to the event to determine the impact of the trauma (Bryant, 2005; Van der Kolk, Pelcovitz, Sunday, & Spinazzola, 2005). Being able to organize and make meaning of an experience is essential in assessing the long-term impact of a stressful environment. Some people have natural resilience or have enough formal and informal support to shield them from some devastating experiences, including being homeless. Several factors support resilience for trauma survivors. These include (a) positive self-perception, (b) disclosure of trauma to others; (c) sense of group identity, (d) altruistic behavior, (e) capacity to find meaning, connection, and binding,

and (f) perceived locus of control (being aware and in charge of what is happening in their lives) (Agaibi & Wilson, 2005). The curriculum sessions focus on incorporating these factors while being conscious of how the stress response manifests itself in internal processing and interactions with others.

Practicing what you preach: Managing case manager stress and organizational stress.

The importance of self-care and the management of organizational stress are often presented as footnotes to curriculum and practice guidelines. This happens because client needs can be so severe that taking the time to discuss caregiver needs can seem a distraction from the central focus; caregivers can feel that they are wasting time or being selfish when they address self-care or the stresses imposed by the organization. Guilt often affects caregivers when they consider their own stress, since they realize that although their needs are genuine, their own life situation is far removed from the stressors their clients face. However, when service providers fail to address their self-care needs, it causes harm. At the very least, if providers lack adequate support, they are more likely to leave the organization and less likely to effectively support the very people they want to help.

When good people leave the organization or stay unsupported and burn out, the mission of the work, the clients, and the caregivers themselves are harmed. Therefore, it is important to have strategies in place to assure that self-care needs are met and organizational stress is managed. This can be accomplished when caregivers (a) understand the impact of working with trauma survivors, (b) understand the factors that increase job satisfaction, and (c) create a plan for self-care. This session focuses on the elements of a useful self-care plan.

Understating how trauma impacts caregivers. Most service providers come to the profession because they themselves have history of adversity or trauma and want be part of the solution. When helpers are exposed to or repeatedly hear about trauma in their clients' lives, their own resolved traumas may be retriggered. In some instances, there may be shared trauma, in which the caregiver and the client have lived through the same or a very similar traumatic experience. Such an experience might be a disaster like a flood or a terrorist attack, or it might be personal violence, such as domestic physical abuse. The level of trauma exposure can be mediated by the quality of self-care and the sense of satisfaction derived from providing services.

More generally, frontline work has its benefits and consequences. The primary benefit of the work is that one is directly and tangibly helping people and helping to solve serious social problems, which can be deeply satisfying and meaningful. Working with marginalized groups to provide help is often inspiring, and the service provided can bring sense of pride and satisfaction. This pride and satisfaction can in turn increase compassion and build resilience in workers (Craig & Sprang, 2010).

When helpers are able to experience or witness their clients' recovery and growth, they experience empathy, insight, and increased tolerance. This can also enhance an overall appreciation for life and improve one's interpersonal relationships and connectedness to others. These are the joys and rewards of the helping field, and the psychological reward anyone gets for somehow helping relieve human suffering.

On the other hand, without adequate support and built-in buffers, repeated exposure to work-related stress can begin as compassion fatigue—short–term emotional exhaustion—but can eventually lead to psychological burnout (Bride, 2007). Psychological burnout is the long-term exhaustion that induces some people to leave the profession; it might lead others to be less

persistent in maintaining client relationships. In some instances, burnout can lead to secondary trauma in which there is an inner transformation of helper by negatively disrupting their world-view (Saakvitine 2004).

The ability to manage stress and avoid burnout directly impacts the level of empathy one is capable of experiencing: burnout can lead to detachment. It reduces empathic concern, which is the ability to respond with warmth and compassion. It also increases personal distress, which generates anxiety and discomfort from watching others suffer. Personal distress can affect the provider's ability to emotionally regulate, and this can result in reduced occupational satisfaction. This harms the helper directly, and can also have escalating consequences for clients and agencies, particularly in areas with limited providers and resources.

Factors that increase worker resilience. Caregivers derive satisfaction from their work when they see growth in their clients. Progress helps spur additional personal growth and more empathy, compassion, and interest. Key factors that contribute to this growth and resilience are 1) training, 2) improved coping strategies, and 3) a supportive work environment (Bride, 2007; Craig & Sprang, 2010).

1) Caregivers cannot adequately support client progress without a strong understanding of client needs. Case managers need appropriate training to be adequately equipped to work with a special population like homeless women.

2) Improving coping strategies means developing a self-care plan that helps one monitor and respond to work related stress.

3) A supportive work environment requires an organization that is mission-focused and provides quality supervision. Reliable peers are also a vital factor in creating a supportive work environment.

Trauma-informed care considers the needs of providers and places strong emphasis on the value and necessity of self-care (Bloom & Farragher, 2011). The centrality of these considerations is one of many points of differentiation between traditional service models and trauma-informed care.

Differentiating Trauma-Informed Service from Traditional Models

Providing case management services in a holistic and trauma-informed manner will empower the women to become stable and more self-sufficient. More generally, all aspects of the service are informed and guided according to how past and current traumatic experiences impact the clients and their readiness for change. Trauma-informed practice acknowledges that the past is relevant to present-day functioning and requires that services are provided in a format that is emotionally safe (Fallot & Harris, 2002). Principles of trauma-informed care include (a) understanding the impact of trauma, (b) creating and prompting safety, (c) supporting choice and autonomy, and (d) providing services in planned way through authentic and positive relationships (Guarno, Konnath, Clervil, & Bassuk, 2009).

This type of service delivery differs from traditional task-oriented case management in several crucial ways.

First, traditional case management typically views each problem or symptom as separate and in need of individual intervention, whereas trauma-informed case management (TICM) sees problems as closely interrelated with the client's past attempts to cope with distressing experiences. TICM seeks patterns issues that stem from the original trauma and does not label as pathology a number of coping strategies that make sense to the client (Herman, 1992). TICM understands many problems such as hypervigilance, sleeplessness, and /or substance abuse as attempts to cope with experiences in an unsafe or distressing environment.

Second, traditional service models draws a line between who is the expert—typically staff—and who needs to be 'fixed' or 'adjusted,' according to the judgment of the expert (Courtois & Ford, 2013). Such an approach can be disempowering to women who have already felt powerless; moreover, it creates an "objective" and distant relationship between the provider and the client. This in turn puts additional stress for clients who are already overwhelmed. Conversely, TICM views the clients as experts in their own lives and the case managers as partners who provide the services that will be most helpful. This is a reciprocal relationship that provides women with the space to exercise choice and control over their future.

Third, traditional services tend to be reactive and crisis-driven. A reactive approach perpetuates chaos and the unpredictability that often exacerbates poor coping (Bloom & Farragher, 2011. Trauma-informed case management aims to establish a strategic plan that is focused on preventing additional crisis, and fosters an environment that does not retraumatize. This is the most paramount difference; trauma-informed care provides a system that does not cause more damage but rather a safe holding environment that becomes a context for healing (Prescott, Soares, Konnath & Bassuk, 2008). This invites the women and their children to experience renewed hope and opens the door for future work should they have an unplanned leave.

Crucially, trauma-informed service delivery is not just well intentioned or a passing fad in the field of human services. The systematic study of human suffering has been the heart of the helping professions since their inception. Freud's first patients were women who suffered sexual abuse in their own families and were experiencing traumatic symptoms in the form of hysteria (Herman, 1992). Political and social movements have often attempted to silence the experiences of those who have experienced trauma, particularly women and children. The diagnosis and

treatment of military casualties, pressure on the health-care system from feminist organizations, and the emergent classification of post-traumatic stress disorder has provided scientific and social momentum to trauma studies (Herman, 1992). Over thirty years of research, as well as the integration of findings from the biological social sciences, have created frameworks within which to better understand how traumatic or adverse events affect the brain, human systems, and overall functioning (Anda et al., 2006; Bloom, 1997; Bremner, 2003; Herman, 1992; Ganzel, Morris, & Washington, 2010). This has led to specific, evidence-based treatment modalities that bring academic rigor to trauma-informed treatments. The present curriculum has been informed by this research and integrates these theoretical principles into a practical guide for case managers.

The Role of Case Managers in Trauma-Informed Care

Because of its holistic nature, trauma-informed case management requires engaged and responsive workers. It is important, however, that engagement does not descend into excessive demand on case-manager or service provider. In fact, over-extended and burnt-out workers unwittingly create unsafe environments. This may occur because they were not present in case-management or group sessions and did not see or what the women were telling them they needed.

Moreover, most human service providers are wounded warriors themselves and have their own history of trauma, either direct or vicarious. Sandra Bloom, founder of Sanctuary Model and expert on organizational stress and trauma, posited that there is no "us and them" between service providers and their clients (Bloom & Farragher, 2011, pp. 63–64). Service providers attempt to manage their clients' distressing emotions of fear, shame, guilt, and anger, while simultaneously trying to manage their own emotions. This is even more pronounced for service providers in rural or suburban areas where services are limited and workers are stretched

extremely thin. As with trauma victims, service providers must be aware of their pattern of functioning in their organizations and of how they manage their own stress and fatigue. This requires effective planning and personal stress management. Self-care strategies are also integrated into this curriculum as guidelines and tools to support these essential practices.

The Goal of this Curriculum and Treatment Format

My personal experience as a worker in shelter system, together with my experience as a researcher and community partner, has shaped the elements of this curriculum. Like any sound treatment manual, this curriculum begins with a strong assessment protocol that includes screening tools and guidance in how to make the assessment both process-oriented and goal-oriented. It also outlines recommendations for managing the roles that you and the clients will occupy in your relationship. With this introduction to the curriculum established, the manual moves into an explanation of what trauma looks like in the lives of homeless women and provides information about how stress and trauma are connected. Guidance is also provided to case managers in managing their own personal and organizational stress. With this foundation in place, the remainder of the introduction outlines the core topics of the curriculum, which include (a) addressing and accessing health and human services, (b) educational issues, (c) employment issues, and (d) parenting. Embedded within these topics are sessions dedicated to developing internal skills such as managing stress and burn-out, maintaining self-regulation, and dealing with grief.

Domestic dispute is the leading cause of homelessness among women in transitional shelters in rural regions (First, Rife, & Toomey, 1994). In light of this, the curriculum also contains a session focused on issues relating to domestic and interpersonal violence. Women who have experienced multiple adverse life experiences often struggle with the dual challenges

of PTSD and substance abuse. This curriculum does not address how to treat substance abuse problems, but it will provide guidelines for establishing an agency screening process and policy on the issue; it also provides a reference guide to affordable treatment manuals on the subject. Lastly, this curriculum will provide guidance in creating connections in the community to link clients to services. A list of free or relatively low-cost resources that will enhance services is also provided.

The curriculum is designed to be flexible and adaptable to agency needs. The case-management sessions can be conducted in any order of topic or focus, but the initial steps of assessment and building safety must be used. Delivering effective trauma-informed services requires knowing the client, oneself, and the community. Moreover, the case management sessions should be structured and conducted in a routine, predictable manner that will be calming to clients who are in active states of crisis. This systematic approach to services frees the provider to focus on what is happening in the session, as opposed to what series of steps should be followed. The curriculum introduces new ways of thinking through each session and can be easily incorporated into your sessions.

This curriculum further provides an opportunity for the organization to review and affirm its mission and to assess its organizational culture. The kit includes tools enabling organizational leadership to support the incorporation of self-care plans into staff development in order to foster resilience as well as recommendations for providing optimal, systematic support to case managers. Organizational leaders need to understand that being friendly and approachable is not enough; problems must be addressed proactively, case managers must be supported, and staff must be provided with frameworks for understanding the dynamics they face in their work. This

may mean revisiting the information on stress responses mentioned in this curriculum or helping them put self-care plans into action.

Elements of the Curriculum

Developing a self-care plan. To be prepared to work with trauma survivors, it is vital that case managers are aware of their own trauma and its effects. In this sense, case managers must practice what they preach. This process therefore begins with a look at one's own trauma history and its impacts. The following section provides a guide to self-reflection that begins with a Life Event Checklist. This checklist will help identify aspects of personal history that may influence professional practice and provides a basis for exploring these experiences as they become involved in work-related stress.

Personal trauma history. The Life Events Checklist, available in Appendix A of this curriculum, will help to identify stressful experiences that may influence worldview and/or professional practice. There is no score for this checklist: it is a tool to help identify past experiences that were and continue to be significant. Individuals completing the checklist should not be required to share their answers with anyone, including supervisors. *The Checklist is a tool for self-reflection only.* Once it is complete, the following questions should be answered.

1. As a child, what stressful events did you experience that strongly affected you?
2. How did you react to the event at that time?
3. How do you react to stressful events now?
4. How do the stressful events that you experienced as a child affect the work you do with your clients?
5. As an adult, what stressful events have you experienced that strongly affect you?
6. How did you react to the event at the time/times it happened?

7. How do the stressful events that you experience as an adult affect the work you do with your clients?
8. After reflecting on the events on your life, what are some things that surprised you?
9. What are things you want to be watchful for or avoid in your work as a result of this review?
10. What are things you remember that would be beneficial to your work?

Creating a self-care plan. After reviewing the Checklist and follow-up questions to identify any salient personal trauma history and its likely professional impacts, case managers can advance to creating a self-care plan. As with the Checklist, this care plan is by necessity personal and flexible. It must begin with being able to identify the stressors that are unique to the specific workplace. Identifying relevant work-related stress, linking it to consequences, creating a self-care plan, and actively monitoring your stress using the Secondary Traumatic Stress Scale are the goals of this section. (The Scale is available in Appendix B.) Three steps will accomplish the creation of this plan.

1. In your work with homeless women and children, identify specific stressors that you find challenging. (Examples include size of caseload, difficulty of cases, or absorbing emotional stress.)
2. Link your stress to consequences. How have these stressors affected you?
3. Identify organizational culture that helps or dampens your work. What are the things in your work that help you deal with stress related to the work? What are things you would find helpful that you want your organization to do?

The answers to these questions will provide a basis for developing a personalized self-care plan.

Table 1 provides a summary of what are known as the domains of life, with examples of what types of factors are present in each domain and how each of these domains contributes to daily function. As a first step in developing the self-care plan, each category should be reviewed to identify areas that are personally meaningful and important.

Table 1: Life Domains

Biological
Nutrition
Sleep
Exercise or activity
Psychological
Work and play balance
Effective relaxation or calming stimuli
Contact with nature
Time management
Interpersonal/Social
Social support
Peer support
Supervision/consultation
Intellectual
Training
Resources
Spiritual
Self-reflection
Meditation
Spiritual connection in community
Cherishing optimism and hope

Once the domains have been identified, completion of the following steps will generate a self-care plan:

1. Select one goal for the category you want to address and determine specifically how you want to address it.

2. Think about any past efforts have you made in the past to address this goal and determine what was helpful. Analyze the resources that are available to you that will help you to address this. What are the stumbling blocks?
3. Determine how you will implement the goal and how you will measure it and monitor it.
4. Share the plan with someone and monitor it.
5. Notice and appreciate the changes.

Self-monitoring. Creating a plan is only the beginning; the implementation and maintenance of the self-care plan is as vital as its creation. Mindfulness of the plan and monitoring it will help assure that self-care becomes a routine and integrated component of professional practice. The Secondary Traumatic Stress Scale*,* found in Appendix B, is a useful tool to help gauge affective responses to stressful events. Specifically, this scale helps detect secondary traumatic stress that may emerge from working with traumatized clients. This Scale can be used regularly at scheduled intervals, during times of particular sensitivity, or at the suggestion of others when signs of stress or burnout may be apparent. It can also be used as a routine, built-in organizational process that is done every month or quarter.

The scoring for the tool for the Secondary Traumatic Stress Scale is as follows.

- A total score at or below 28 = Little or no secondary traumatic stress
- A total score of 28-37 = Mild secondary stress
- A total score of 38-43 = Moderate secondary traumatic stress
- A total score of 44-48= high secondary stress
- A total score of 49 and above = Severe secondary traumatic stress

The score ratings can provide guidance about what self-care steps are needed. Generally, a score of 38 or above will indicate that active steps must be taken to address the stressors.

It is possible that even with a well-implemented self-care plan, secondary traumatic stress can remain high. In these cases, it is important to identify other sources of support. Where support in the workplace is available through supervisors or consultants, these should be accessed. If that is still not sufficient, professional counseling or therapy is strongly advised. It can be surprising to helpers to find that they are sometimes themselves resistant to getting help. It is important, however, to remember that there is no shame in getting help; and being self-aware and reflective not only helps the case manager but improves the quality of service that is provided to others.

Evaluating organizational support. For organizational support and change, there are two tool-kits that are publically available and free of charge. They are *The Long Journey Home: A Guide for Creating Trauma-Informed Services for Mothers and Children Experiencing Homelessness* and the *Trauma-Informed Organizational Toolkit for Homeless Services*. They can be found on the Internet at the Homeless Resource Center (http://homeless.samhsa.gov/). The Homeless Resource Center is dedicated to sharing knowledge and best practices to prevent and end homelessness and is funded by the Substance Abuse and Mental Health Administration. The toolkits can be used to help organizations create a strategic plan for establishing a trauma-informed environment. The Center also provides resources to support agencies in self-assessing their physical and cultural environment and to help direct policies and procedures. Each toolkit is geared to specific types of organizations, so a review to determine fit is necessary prior to selection.

The Trauma Center at the Justice Resource Institute (http://www.traumacenter.org/index.php) has also developed an interactive training DVD and manual called *Developing Trauma-Informed Services for Families Experiencing Homelessness*.

The material is free, but there is a charge for shipping and handling. The materials can be ordered through their website, or by mail:

Shannon Smith, Program Assistant
The Trauma Center at JRI
1269 Beacon Street, 1st Floor
Brookline, MA 02446
Ph: (617) 232-1303 x 203

Organizational change is long-term, and by nature a difficult process. Agencies that have access to funds may be well-served by using professional trainers to help implement trauma-specific interventions. There are several evidence-based interventions, and they can be found through the National Center for Trauma-Informed Care (http://www.samhsa.gov/nctic/), which is also supported b the Substance Abuse and Mental Health Services Administration. The Center's website provides a section dedicated to trauma-informed care and trauma-informed services. Under " Trauma- Specific Services," the Center shares well-researched models that organizations can adopt or adapt as appropriate to the needs of their programs and the types of trauma they confront in clients. I highly recommend looking at the Sanctuary Model; it is intended for residential settings and has been implemented in shelters.

Establishing rapport with clients. Building safety is the foundation for trauma-informed care; it starts with knowing oneself and the clients. The previous sections outlined ways to self-assess and reflect on work-related stressors. This section will focus on how to create a relationship that is safe and predictable for the client, and will lay the groundwork for how to conduct future sessions. First, the foundations of treatment are reviewed. Next, screening and assessment tools are recommended. The section ends with recommendations on how to proceed with interventions.

For people in crisis, establishing stability and safety is paramount. This is especially vital for homeless women and their children. Both the service provided and the method of delivery are essential in communicating trust. Therefore, it is critical to remember the following foundational elements of trauma-informed care:

1. Exposure to and experiencing trauma create a lasting imprint on the survivor.
2. The past is never irrelevant to current reactions.
3. Survivor behaviors that were once useful can now be ineffective and destructive.
4. Understand that people are reacting normally to abnormal situations.
5. Those seeking services are still in survival mode when they come for services and may have lived their entire lives in that state.
6. Those with cumulative trauma histories are prone to being re-victimized because of their assumptions about the world.
7. The service environment must be safe and emotionally regulated so the clients can explore their issues.
8. Respectful empathy is crucial.
9. Don't confuse understanding trauma as inviting drama or as a way of infantilizing individuals so they are not held responsible for their behavior.
10. You cannot make up for client's pasts or try to rescue them. But you can provide an alternative path (Courtois & Ford, 2013).

It is important to remember that relationship is the mode in which people change. The relationship between the caregiver and the client is part of the treatment, and a positive experience can create context for change and healing.

Assessment goals and process. The purpose of assessment is twofold: to get detailed information regarding client trauma history, and to establish a rapport so that a supportive relationship can be developed. Although the case manager guides the assessment, it is important to remember that this is a mutual process: just as the case manager is assessing the client, so too is the client assessing the case manager. Many homeless women have shared that they have "gotten the run-around" when they attempt to access services and are made to "jump through a lot of hoops." Because homeless women have been repeatedly let down, their being guarded is not just learned response, but a safe practice. Thus, it is the primary responsibility of the case manager to create a safe working relationship. In order to do that, to the case manager must have a plan for the assessment: how the client will be approached, what information is needed, and what services are likely to best meet her primary needs.

Approaching the client. Once a client is assigned, a case manager should make an effort to contact the client and schedule an appointment for the assessment session. Note that there should be an agency policy in place that states that a tour of the facility must be given to the clients within the first 24 hours of arriving. Often, women are shown to their room or unit and left to figure out where things are or what to do until their case manager makes contact with them, which could be several days. This makes the women feel less welcome in the facility and can create uncertainty and stress.

This sort of neglect generally occurs not out of malicious intent, but because of strained resources and overburdened staff. In some cases, a client is admitted to a shelter in the middle of the night. Hence, it is important that shelter policy mandates a tour of the facility upon entry so the client knows the basic layout. This includes the locations of the bathroom, kitchen or eating area, proper entrance and exit to shelter, and a place to get help or phone for services.

Upon entry to the shelter, the woman should be asked if she (together with any accompanying children) has food or has eaten during the last few hours. If not, she should be shown to a pantry, which should be stocked with foods that do not require refrigeration or heating. These basic services let the client know that you care about their well-being and are prepared to meet their basic needs.

With these orientation elements addressed, the assessment process can continue. Whenever possible, background information on the client should be reviewed prior to approaching her, including her name and the names of any children. This will help communicate concern and care. Bring an appointment reminder or piece of paper to write down the potential appointment time and contact information. This will help anchor the client and provide a physical reminder of her appointment.

Upon first meeting, the case manager should introduce him- or herself and explain the case manager role, including responsibility for helping the client to get settled in. That done, it is appropriate for the case manager to request permission to be introduced to the children. If a child is small, bending to the child's level to say hello is often reassuring. In general, one should be cautious about physical contact beyond a handshake of introduction. Hugging or other touching is not recommended, as it can be viewed as intrusive or may retrigger memories of unwanted advances by someone in power.

With introductions complete, the first meeting must be scheduled. This meeting should take place as soon as possible. Once the appointment is scheduled, the case manager should provide a written note of the appointment, along with their name and office number in the event there is a need to reschedule. If possible, the client should be shown the meeting location. Some homeless women are illiterate or have very limited literacy, and may therefore not be able to

understand what you wrote. If children will be present, finding out which toys, activities, or other things they like can help prepare for their visit. If the child has a particular toy or object that can keep her or him engaged during the meeting, the mother may be invited to have the child bring it. This is helpful in putting both mother and child at ease, and will also minimize interruptions during the meeting.

Assessment session. Following the intake of personal information and a review of agency policy, an assessment session is conducted. Policy and procedure reviews should not be conducted in conjunction with a personal assessment, as this is likely to be overwhelming for the client. The purpose of the first session is only to clarify the role of the case manager and to gather information on the types of trauma the client has experienced. If there is time during this first appointment and the climate seems conducive, it may be acceptable to do a screening for substance abuse. The information on substance abuse screening and treatment will addressed in a subsequent session, but gathering this information early can aid in assessment during the next appointment.

Prior to the first visit, the office should be prepared to ensure that it is tidy and has good lighting. If children will be present, having low-noise, age appropriate toys or will help keep them occupied while the manager working with the client. These can be coloring books, puzzles, Legos, Play-Doh, or for older children, books or magazines. If available, video games or laptops with headphones can also keep children busy for extended periods of time. The better occupied the children are, the more comfortable the mother can feel to share her history without sharing information she does not want the children know.

After settling into the office, pleasantries can help the client feel at ease. Asking about how she is settling in and how the children are doing conveys concern and can help identify any

immediate needs she is experiencing. If a need is expressed, that need should be noted and the client should be told how and when the need will be addressed. Identifying immediate needs can also alleviate the sense of crisis and help the client focus on the assessment.

To help build in predictability, the case manager should always discuss the aim of the meeting at the beginning of the session. In this instance, because it is the introductory session, you will review how case management sessions will be typically conducted and share information on what the client can expect from you and what you expect from her. You will also be doing a trauma exposure assessment to get better understanding of her history. You start by can sharing a bit of your background and let her know that you hope to get to know her better so you can assist her in the best possible way. To help her understand how your case management sessions will typically conducted, you need to cover:

- The way your meetings are typically organized (frequency, duration, length);
- Your availability;
- The role of confidentiality and when you have to break it;
- The ways staff at your shelter handle conflicts or problems;
- The client's right to refuse to answer questions she is uncomfortable with, and that it will not jeopardize her continued residence;
- The fact that the client can also take breaks as needed; and
- The assurance that you will be responsible for the items you both agreed you will perform.

Doing this builds in boundaries and helps set a tone the client can predict. In addition to these rights, the client also has responsibilities that must be met. These may include:

- Attending scheduled meetings;

- Making reasonable attempts to notify you if they need to reschedule;
- Being honest;
- Respecting other residents;
- Using services in good faith; and
- Consenting not to leave without notice or discussion.

As the client's responsibilities are outlined during this meeting, it is important that the client also understand that the case manager shares responsibility in this process.

Because some trauma survivors can be impulsive, it is necessary to plan around possible compulsion. In this way, the client can be better grounded and prevented from doing serious damage—whether to others or herself. Failures and relapses are best planned for by talking about the possibility. It is important that the case manager convey their desire to earn the client's trust but also acknowledge that this will take time.

Client history. The next steps are dedicated to understanding the types of traumas the client has experienced. To accomplish this, the case manager will need to understand when things happened, how long they occurred, and how they affected the client at the time as well as now. There are several valid and reliable trauma exposure screening and assessment tools available. The International Society for Traumatic Stress Studies (ISTSS) is an organization dedicated to promoting and disseminating knowledge about traumatic stress. ISTSS provides resources on assessing trauma and offers scientifically sound assessment and screening tools. However, for certain tools, license or certification is required, and some are fee-based. If resources do not permit the use of these resources, the Life-Stressor Checklist–Revised is recommended. (The Checklist is available in Appendix C.)

The Life-Stressor Checklist-Revised is a trauma exposure screening tool that has specific questions designed for women and can be publically accessed at no charge. It has been used with women in shelters and reported useful (Wolfe & Kimerling, 1997). A sample of the tool is included in the appendix of this curriculum. For screening purposes, there is no need to keep score. A client answering *yes* to a question will indicate her exposure to a stressor.

After selecting a reliable screening tool, the case manager should read the questions to the client and write down the answers. Some practitioners have argued that giving the client the option of filling a form rather than having the case manager read the questions would be more trauma-informed (Courtois, 2004: Najivtis, 2002). Although offering choice is a trauma-informed principle, I have found in my own experience that taking the time ask the questions oneself is better for building rapport. Because the educational and literacy level of the client is unknown, reading the questions is a safer and more considerate option. As the relationship progresses, the case manager can determine the best method for a particular client. For the first assessment, however, I recommend reading the questions aloud and recording the answers yourself.

This script can prepare the client to answer the questions:

> *I am interested in learning more about your history and your recent experiences. This will help me get to know you better so I can help you meet some your goals. The information you will share with me will help me understand your reactions to what is happening to you now and perhaps in the future. I am going to be asking questions about your past that is personal. You do not have to answer any questions you are not comfortable with.*
>
> *Your stay with the shelter or program will not be taken away if you do not answer the questions. How would you like to tell me that you do not want to answer a*

> *question? Some people say " I am not comfortable answering that"; others simply say Pass*. (Wait to get an answer before moving forward).
>
> *You can also take breaks as needed. You can let me know by telling me you need a break or I will ask you if you need a break if I sense that you might need some space.*
>
> *The questions I ask will be about events that might have been stressful, frightening, or upsetting to you. An example of this will be a question about a serious accident or disaster or things related to your childhood like seeing violence between family members. These questions will help me understand how we should approach certain goals.*
>
> *For instance, for some people who grew up in foster care, going to the assistance office to get help with food stamps is very difficult. I will help them make a plan for how to handle the stress of facing something difficult because I will know about their past. Does this make sense? Do you have any questions for me before we get started?* (Pause to get an answer and clarify any questions they may have.) *Okay, if you are ready, I would like to get started.*

At the conclusion of the assessment, the client should be thanked and reassured about its purpose. For some people, talking about the past might be retriggering and upsetting. This may be evident during the session, or for some it might happen when they go back to their room or unit. Informing the client that this may happen can help reassure them that their experience is normal and expected.

The client may be able to discuss how they normally respond when she is upset and how they deal with it, and the case manager can ask about what she does when she becomes upset. This may be an opportunity for client and case manager to brainstorm some de-escalating strategies—for example, taking and releasing deep breaths, journaling, having contact with

nature, or talking to a reliable friends. If feasible, case managers may even offer themselves as a resource. Coping strategies can be practiced during the session.

At the end of this assessment session, the next session can be scheduled. Prior to concluding the meeting, it is good practice for the case manager to go over any questions the client might have or simply to share information with the client. The information on substance abuse screening and treatment is presented in the materials for the session ("Substance Abuse") that follows the assessment. This section will detail the screening tools and help to plan agency policy and responses to substance abuse issues.

Post-session notes. Following the meeting, the case manager should review client responses and note the experiences to which the client has been exposed and that have had a significant effect. Noting these elements of the assessment will support goal-setting and planning later in the process. The case manager should also determine whether there are any serious issues that need to be shared with staff or a supervisor in order to help stabilize the client. For instance, if the client reveals that she grew up in foster care and you note that during the session she was unresponsive to her children's needs or very harsh or punitive with them, you may seek support from your team on how to build rapport with your client to promote healthy parenting.

Substance abuse. Homeless women and mothers often have histories that include using or abusing drugs and alcohol (Hopper, Basuuk, & Olivet, 2010). A dual diagnosis of posttraumatic stress disorder and substance abuse is common among women who have been exposed to trauma (Najavits, 2002). Because of this, the agency or shelter providing services needs to have a formal policy on how to screen and address issues related to substance abuse. In larger population centers, there are shelters that target sub-populations of homeless women and include substance-abuse treatment as an integral part of the services they provide. Other shelters

have a zero-tolerance policy for those using or abusing substances while receiving shelter services. In my experience, in rural and suburban regions, shelters tend to have a zero tolerance stance and women must be clean to qualify for admittance. Regardless of policy, however, all service providers need to have a screening process for substance abuse so they can adequately understand the clients they service. This section of the curriculum outlines ways to conduct an assessment and provides recommendations for screening tools.

However, prior to administering any screening tool, the agency should also have a policy on how to respond to the need of women who have substance abuse issues. If there is not an articulated policy at the shelter, the process outlined in this section will help guide policy formation as well as respond to client needs. This starts with staff awareness of the resources in the community that address substance abuse, including the level of care and treatment modality. This will help determine how resources and referrals should be handled for clients in need.

Typically, substance-abuse treatment models may be inpatient, residential, intermediate, or outpatient (SAMHSA TIP, 2012). Inpatient facilities may include medically supervised detoxification that is accompanied by intense inpatient treatment. The same facility maybe able offer outpatient services or provide referral to agencies that offer specialized treatment for substance abuse. In both inpatient and outpatient facilities, there must be personnel who are appropriately trained to treat addictions, have comprehensive screening and assessment process, staff trained service providers, and offer varying types of treatment modalities such as group or individual.

Screening service providers. Before recommending or using an agency, the case manager must be aware of the services it provides as well as the quality and rigor of the service. This entails understanding the nature and scope of available services. It would be best to make an

appointment with a potential service provider so as to see the facility first hand and help build a rapport with the agency, and while there to ask detailed questions about the nature and scope of the services provided. The Managed Health Care Organizational Readiness Checklist is a useful tool to help the case manager interview the service provider. The Checklist was developed to help treatment providers engage in self-assessment of service providers and their services. It assesses multiple domains, including the type and character of services provided, staff training, management and marketing, and organizational relationships. Although designed for self-assessment, the Checklist can be adapted to interviewing substance-abuse care providers about the services they offer.

From this standpoint, the two domains of Service Characteristics and Service Comprehensiveness are most relevant. Some examples of the questions in the domains mentioned include inquiries about screening and assessment services, network relationships with other providers, skill levels of staff, and focus of service. (The domains with the corresponding questions are listed below and included in Appendix I; Appendix J: Resources, includes a reference to access the entire checklist.) Although the responses are on a Likert scale, meaning they range from never to always, the person asking the questions can prompt for more details following a question on the scale. For example, the first question in the Service Comprehensiveness domain asks whether the provider offers centralized screening, assessment, intake, and crisis intervention services. Regardless of the response to any of the questions, pressing for details on how and what tools are used helps yield a more comprehensive understanding of the services provided.

Although a scoring instrument is provided to help gauge the levels of each response, formal scoring is not necessary. The checklist can be used merely as an interview tool to help the

case manager understand the scope of the provider's services. However, if needed, scores can be tallied for each section that indicate the strength or weakness of the services in each domain. The total score for each domain can range from 1 to 5, with 1 as the weakest position and 5 as the strongest. For scoring on the Adult Services Comprehensiveness domain, individual response scores are summed and then divided by 6 to get a composite score. For Service Characteristics, individual response scores are summed and divided by 12 to derive the score. Each composite score demonstrates the strength or weakness of the agency in relation to the domain.

Below are the questions for Service Comprehensiveness followed by questions on Service Delivery:

Figure 1: MHCORC Service Comprehensiveness

No, None, Never	Very Limited, Not Often	Partially, Frequently	Mostly, Regularly	Yes, Fully, Always
1	2	3	4	5

Service Comprehensiveness

For adults, do you deliver:	*Please circle the answer...*
1. Centralized screening, assessment, intake, and crisis intervention services?	1 2 3 4 5
2. Comprehensive outpatient services?	1 2 3 4 5
3. Intensive outpatient services, or do you have strong network relationships with providers of such services?	1 2 3 4 5
4. Partial hospitalization/day treatment services, or do you have strong network relationships with providers of such services?	1 2 3 4 5
5. Short-term residential treatment, or do you have strong network relationships with providers of such services?	1 2 3 4 5
6. Inpatient treatment, or do you have strong network relationships with providers of such services?	1 2 3 4 5

Figure 2: MHCORC Service Characteristics

No, None, Never	Very Limited, Not Often	Partially, Frequently	Mostly, Regularly	Yes, Fully, Always
1	2	3	4	5

Service Characteristics	*Please circle the answer...*
13. Do you have skilled clinical staff assigned to all aspects of the screening and assessment process, including initial telephone contacts?	1 2 3 4 5
14. Do your services ensure rapid access (1-2 days) to assessment services and initial placement?	1 2 3 4 5
15. Do your services have a brief intervention focus, e.g., six to eight sessions for outpatient care, for most patients?	1 2 3 4 5
16. Do you have internal case management services for focusing on repeating patients and others who have high utilization patterns?	1 2 3 4 5
17. Do you have ensured linkages with primary healthcare providers for needed healthcare?	1 2 3 4 5
18. Do you adapt standard services to meet the needs of special populations, such as mentally ill substance abusers, injecting drug users, and pregnant addicts?	1 2 3 4 5
19. Are service needs constantly reevaluated, and service plans modified, based on patient progress?	1 2 3 4 5
20. Are admission, treatment, and discharge criteria in place and used consistently by staff?	1 2 3 4 5
21. Do your admission, treatment, and discharge criteria take into consideration the practice standards of managed care firms with which you have (or hope to have) contracts?	1 2 3 4 5
22. Do your services ensure rapid linkage to succeeding levels of care?	1 2 3 4 5
23. Do your services emphasize family involvement and use of natural support systems, including self-help groups?	1 2 3 4 5
24. Do your services focus on patient outcomes and satisfaction?	1 2 3 4 5

In some cases, of course, there may be only a single substance abuse provider for the community. Even if that is the case, as a matter of proving quality and trauma-informed service, one must be aware of the scope and quality of services provided to the referred agency. Obviously you will want to avoid referring clients to service providers who are ill equipped or who may cause damage to fragile or vulnerable clients because of how they provide services. Conversely, a responsive substance-abuse treatment provider may become a strong connection and ally that benefits both agency and clients.

Screening process. If there are no adequate facilities locally or there are significant barriers to accessing treatment centers, an agency must decide how it will respond internally to the clients who present with substance abuse problems. At the basic level, the agency must be aware of the substances the client is using or has been using; this requires a screening process. The process may use a screening tool only or a screening tool together with a drug panel test. The benefit of conducting a drug panel is that it helps establish a baseline and immediately identifies those who cannot be admitted for services under a zero tolerance policy. It helps to clearly communicate that a drug-free environment is an agency priority and reduces the likelihood of traumatic evictions of clients discovered to be abusing. It is distressing for the client who is abusing substances to worry about getting caught and jeopardizing her continued residence. A clearly known and established norm provides safety and predictability.

However, this is a double-edged sword. Giving a drug panel test involves getting a urine sample, which entails staff being present while the person is eliminating. This process and the test itself are extremely intrusive and can feel like a violation. Specifically, this process can be difficult for women who have histories of incarceration or any other confined residential setting. Even collecting a urine sample can be a degrading experience, and being subjected to it can cause severe distress.

Moreover, making admittance to service conditional on being clean can be poor policy if the agency is the sole provider of shelter services. As noted previously, homeless women use substances to cope with extremely distressing circumstances and to help manage their internal hyperaroused state. If this is a known condition of the population being served, refusing services for those who need it is punitive and inconsistent with agency mission. A more trauma-informed approach would be to determine the prospective client's level of use or abuse and offer services

and referral as part of the initial assessment. It is, however, finally up to each agency to determine how it will implement policies on substance abuse.

Screening clients. The role of the case manager here is to assess the severity of substance abuse and help connect the client to more specialized services if the resource is available. Screening for past and current use will help the case manager understand how the client uses alcohol or another drug to cope, and what if any obstacles it presents to meeting current goals. Substance-abuse screening tools can be used to delineate the type of substances, the frequency of use, and the negative consequences that have resulted from use/abuse. The client's past attempts to stop or control substance abuse are also relevant. In any case, using a screening tool will help the case manager determine if there is a need for additional services or whether additional assessments should be administered for better understanding.

The Substance Abuse and Mental Health Services Administration (SAMHSA) provides extensive public resources, including assessment and treatment tools for substance abuse treatment. SAMHSA's (2005) Treatment Improvement Protocols (TIP) provide best-practice guidelines for substance use disorders, and TIP 42 specifically provides information on substance abuse treatment for persons with co-occurring disorders. TIP 42 offers wide range of screening and assessment tools for substance abuse including the Simple Screening Instrument for Substance Abuse Interview Form (SSI-SA). The SSI-SA assesses the level and severity of substance consumption in the past six months. A sample of the tool along with the scoring material is located below and in Appendix E. It includes an introductory statement and guides the practitioner through the interview process. After the interview, the scoring section will help determine if additional assessment or referral is needed.

Figure 3: Simple Screening for Substance Abuse

Simple Screening Instrument for Substance Abuse Interview Form

Note: **Boldfaced** questions constitute a short version of the screening instrument that can be administered in situations that are not conducive to administering the entire test. Such situations may occur because of time limitations or other conditions.

Introductory statement:

"I'm going to ask you a few questions about your use of alcohol and other drugs during the past 6 months. Your answers will be kept private. Based on your answers to these questions, we may advise you to get a more complete assessment. This would be voluntary—it would be your choice whether to have an additional assessment or not."

During the past 6 months…

1. **Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opioids, uppers, downers, hallucinogens, or inhalants.)** (yes/no)
2. **Have you felt that you use too much alcohol or other drugs?** (yes/no)
3. **Have you tried to cut down or quit drinking or using drugs?** (yes/no)
4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.) (yes/no)
5. Have you had any of the following?
   - Blackouts or other periods of memory loss
   - Injury to your head after drinking or using drugs
   - Convulsions, or delirium tremens ("DTs")
   - Hepatitis or other liver problems
   - Feeling sick, shaky, or depressed when you stopped drinking or using drugs
   - Feeling "coke bugs," or a crawling feeling under the skin, after you stopped using drugs
   - Injury after drinking or using drugs
   - Using needles to shoot drugs
6. Has drinking or other drug use caused problems between you and your family or friends? (yes/no)
7. Has your drinking or other drug use caused problems at school or at work? (yes/no)
8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.) (yes/no)
9. Have you lost your temper or gotten into arguments or fights while drinking or using drugs? (yes/no)
10. Are you needing to drink or use drugs more and more to get the effect you want? (yes/no)
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs? (yes/no)
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone? (yes/no)

Simple Screening Instrument for Substance Abuse Interview Form

13. Do you feel bad or guilty about your drinking or drug use? (yes/no)

    Now I have some questions that are not limited to the past 6 months.

14. Have you ever had a drinking or other drug problem? (yes/no)
15. Have any of your family members ever had a drinking or drug problem? (yes/no)
16. **Do you feel that you have a drinking or drug problem now?** (yes/no)

- Thanks for answering these questions.
- Do you have any questions for me?
- Is there something I can do to help you?

Notes: _____

_____

_____

_____

_____

_____

Observation Checklist

The following signs and symptoms may indicate a substance abuse problem in the individual being screened:

- Needle track marks
- Skin abscesses, cigarette burns, or nicotine stains
- Tremors (shaking and twitching of hands and eyelids)
- Unclear speech: slurred, incoherent, or too rapid
- Unsteady gait: staggering, off balance
- Dilated (enlarged) or constricted (pinpoint) pupils
- Scratching
- Swollen hands or feet
- Smell of alcohol or marijuana on breath
- Drug paraphernalia such as pipes, paper, needles, or roach clips
- "Nodding out" (dozing or falling asleep)
- Agitation
- Inability to focus
- Burns on the inside of the lips (from freebasing cocaine)

Scoring for the Simple Screening Instrument for Substance Abuse

Name/ID No.: _____ Date: _____

Place/Location: _____

Items 1 and 15 are not scored. The following items are scored as 1 (yes) or 0 (no):

___ 2	___ 7	___ 12
___ 3	___ 8	___ 13
___ 4	___ 9	___ 14
___ 5 (any items listed)	___ 10	___ 16
___ 6	___ 11	

Total score: ____ Score range: 0-14

Preliminary interpretation of responses:

Score	Degree of Risk for Substance Abuse
0-1	None to low
2-3	Minimal
>4	Moderate to high: possible need for further assessment

If the scoring reports reveal moderate or high level of risk for substance abuse, the individual should be referred for a formal assessment by a substance-abuse service provider. Alternatively, case managers can conduct the nuanced assessments themselves using instruments recommended by SAMHSA. I would recommend using the Drug Abuse Screening Test (DAST) as an additional assessment. The DAST is another brief questionnaire that is well-validated, reliable, and useful for identifying individuals who are using psychoactive drugs for the past 12 months. It is accompanied by the guide for questionnaire and scoring key, at nominal cost. (A sample of the DAST and scoring is included in Appendix H.)

After screening and assessing the severity of substance abuse, the case manager and client can determine how much, if any, of case management sessions should be tailored around treating the abuse problem. If the client is actively working on recovery, the case manager can

help the client continue to monitor and work on her sobriety. This entails continuously reviewing her treatment plan and her service providers, and linking her to needed services. If the agency has identified a significant group needing attention, there could be group sessions aimed at addressing trauma and substance abuse. For this purpose there are affordable, evidence-supported treatment manuals that one can use. They can be accessed via the Trauma-Specific Interventions section of the National Center for Trauma-Informed care website or the list of resources in Appendix J.

Planning sessions. Case management is a critical component of providing shelter services because it concretely addresses clients' pressing needs; it entails assessing, planning, lining, monitoring, and advocating (Mueser, Bond, Drake, & Resnick, 1998). By addressing the basic needs of the clients while aware of how their past trauma influences their engagement with their environment, one can promote stability and help develop self-sufficiency. To prepare and conduct trauma-responsive sessions, case managers must determine which issues to address, identify their role and the client's role in the plan, and have a framework for how the agency will provide needed services (Morse, 1999). This session will address strategies for preparing for sessions and will discuss motivational interviewing and stages of change in the transtheoretical model as helpful modalities for engaging in trauma-informed client support.

Engagement process. To build a relationship and actively assist the client in meeting her basic needs, the helping relationship between provider and client must be open, dynamic, and well sequenced: not merely checking in, but also not overwhelming and pushy. To accomplish this task, the case manager needs to adopt a stance that is flexible and accommodating and must have a plan for sequencing the change process. Motivational interviewing is an approach that is based on a humanistic model and is a strong fit delivering case management services. (Miller &

Rollnick, 2002; Miller & Rollnick, 2013). Motivational interviewing assumes that people have strong capacity for change and aims to encourage the client to *choose* to change her or his behavior (Miller & Rollnick, 2002). Clients need differing types and levels of motivational support as they progress toward their goals; motivation-based strategies are flexibly paced and generally work well for walking clients through change.

Motivational interviewing. Motivational interviewing (MI) follows a set of principles that sequence intervention according to when the client is ready for change rather than when the helper prefers that the change occur. The principles that guide the helping process are as follows:

1. Treatment is client-centered and process-oriented;
2. The relational stance focuses on partnership, acceptance, compassion, and evocation;
3. The strength and frequency of change talk affects the client's behavior;
4. Ambivalent response or desire to maintain current behavior is normal and does not signify that the client is being resistant;
5. Developing discrepancy between client goals and current behavior helps focus treatment; and
6. Supporting hope and confidence impacts behavior (Miller & Rollnick, 2002; Miller & Rollnick, 2013).

Motivational interviewing acknowledges that the client is not necessarily ready to actively engage in change behavior when she presents for services. Often, the helper must be her ally in helping her navigate through her motivation to change and her struggle to sustain the needed changes. Miller and Rollnick (2013) outline the central processes that are apart of MI as engaging, focusing, evoking and planning. Engaging the client is fundamental to the treatment process; and empathic and reflective listing, described in more detail below, helps establish a

working alliance with the client. Engagement will lead to the focusing process in which the topic or issue the client wants to discuss is brought forth. The topic may be different from what the clinician planned, but shifting the focus to something the client wants or is more willing to do will shape the treatment goals and is adheres to trauma-informed practice.

Strategic evoking, in which the practitioner elicits the client's own motivations for change, is the directive approach that distinguishes MI from other helping frameworks. In strategic evoking, clients are assisted in talking themselves into changing; it is directive and focused. The planning process naturally follows the decision to make change, and infusing the client with authentic hope and optimism about her ability to change is crucial for helping sustain the change during roadblocks.

Specifically, empathy is expressed via *active and reflective listening*. Active and reflective listening entails asking open-ended questions and not inserting advice or opinion. The helper repeats back or closely paraphrases what the speaker is saying in a straightforward way, reflecting what the helper hears from the speaker, and summarizing and linking elements of what the speaker has said in order to shift the conversation. Active and reflective listening engages the client and attunes the case-worker to what the client needs, in a process Miller and Rollnick (2013) call "accurate empathy" (p. 61). Being acknowledged and feeling heard and understood is a powerful experience for most individuals; it is even more significant for members of marginalized groups such as homeless women. Such empathic engagement builds safety and rapport, and is critical component of trauma-informed care (Bloom, 1997).

Individuals who present for human services often feel ashamed and have internalized their failures. Direct confrontation or expressing disappointment in their poor coping makes them feel even more shame and does not motivate change. On the other hand, the opposite may occur

when clients are eager to accomplish their goals without having sufficient supports or may say they want to accomplish a task but behave as if the reverse were true. For instance, a client may say she is ready to get a job, but make no effort to look for jobs or even get out bed until late in the day. Motivational interviewing acknowledges this pattern and asserts that the helper should not engage in shaming confrontation (Miller & Rollnick, 2013).

Instead, when the helper points out the discrepancy between expressed value or desire—in this instance finding a job—and behavior—like staying in bed all day—the client is compelled to decide how important it is to change. Often, clients are aware of the discrepancy between their behavior and their desired goal. The role of the helper here is to increase this discrepancy in the client's perception by calling attention to it and by having the client evaluate her own behavior and further discuss her desire to decrease the discrepancy. This entails discussing the benefit of maintaining the displayed behavior (in this case perhaps getting much-needed rest is the benefit of sleeping in) and weighing it against the desired behavior. This prompts the client to argue for or evaluate their need their own change and address the barriers to their desired behavior. This is when being optimistic and expressing confidence in the client's ability to meet her desired goal or at least augment the desired behavior is critical. Hope, coupled with tangible support, increases *change talk*.

Change talk occurs when the client recognizes the disadvantage of the status quo and acknowledges or recognizes the advantage of change. When the helper sees the client move toward this behavior, she or he can help the client self-assess her readiness for change. Motivational interviewing hinges on the essential question of how important the goal is and how confident the client feels about her ability to make the change. As these questions are answered, the client must evaluate a number of things, including how she has attempted to address the issue

in the past, what challenges might arise when trying to make the change, and how she can respond to those challenges.

Transtheoretical model and stages of change. As in motivational interviewing, the transtheoretical model asserts that behavior changes occur over time by accomplishing a set of tasks (Norcross, Krebs, & Prochaska, 2010). The transtheoretical model is often paired with motivational interviewing because it aids the helper in recognizing when the client is ready for change (Courtois & Gold, 2013; TIP, 1999). In the transtheoretical model, the five stages of change are: *pre-contemplation, contemplation, preparation, action,* and *maintenance*. For each stage and change process, there is a relational stance the helper should adapt to produce the best results in the help process (Norcross et al., 2010). The stages, each with its accompanying relational stance, are further explored below.

Pre-contemplation. In the pre-contemplation phase, there is no intention to change behavior in the future (Norcross et al., 2010). The person is aware of her problem because others around her suffer the consequences of it, but she does not experience her behavior as problematic. In the mentioned example of the woman who says she is looking for a job, the excessive sleeping may not be a problem for her, but it may be for the case manager or for the women's children who are made chronically tardy or absent from school. The relational stance that accompanies pre-contemplation is a nurturing parent (Norcross et al., 2010). To reflect this stance, the case manager would engage in empathic reflective listening and have the client explore her feelings on the issue. There is no advice-giving or prompting for major change in behavior other than asking for compliance with the shelter policy. In this case, it may be ensuring that the children attend school regularly.

Contemplation. In the contemplation phase, the client is aware of the problem and is seriously thinking about overcoming it (Norcross et al., 2010). However, the positive evaluation of the behavior and the amount of effort involved in overcoming the problem behavior seems considerable. At this stage, the relational stance would be that of a Socratic teacher who encourages the client to achieve insight into her behavior (Norcross et al., 2010). In this instance, exploring the benefits and consequences of sleeping in, as opposed to actively looking for jobs, would help clarify the function of each behavior. The woman may share that she is physically exhausted and overwhelmed by the steps involved in undertaking a job search. In this phase, exploring the client's history with finding, gaining, and maintaining employment would be helpful in understanding the stress reaction she is exhibiting and help her achieve insight into her resistant behavior.

Preparation. The contemplation phase is followed with preparation phase, in which the client is intending to take action and will make small behavioral changes (Norcross et al., 2010). In this case, the cage manger's relational stance would be that of an experienced coach who will help the client build a game plan. This is the stage in which active linkage and advocacy are necessary. Continuing with the example, the case manager may notice that the woman is getting up early and making sure the children are attending school on time and not going back to bed after she returns from the bus stop. She may also ask the case manager to give her list of job openings. This is the opportunity to create a detailed plan and respond to change talk with optimism and hope.

Beyond an optimistic and affirming response, the case manager should also guide a discussion of how to prepare to enter the job market (resume and appropriate wardrobe) and, if the client secures an interview, discussion about how to respond to challenging scenarios. There

should be multiple sessions on planning the job search and delineating which aspect the case manager would be responsible for—perhaps getting in touch with local resources or with businesses that are hiring and making sure that job listings are accurate and accessible. The plan would also establish a manageable behavior plan for the client that might include: contacting the career office for help with building a resume; creating the resume; having the case manager review the resume; and storing the resume in an accessible and safe place. In each phase, there should be a discussion of potential challenges, like having transportation to get to the career or employment office and how to overcome any logistical obstacles.

Action. The action phase is where there the most overt behavioral change toward achieving the desired outcome occurs. The role of the helper is that of a consultant who provides expert advice and gives support when there are barriers (Norcross et al., 2010). In this case, the client has identified a job she is interested in, has a proper resume and attire, and has applied for the job. The case manager would help her navigate through the application process, such as an online application followed by a paper one. The client may become discouraged because, for example, she feels that her criminal record may prevent her from securing an interview. This would be when the case manager would educate her concerning which parts of her criminal history must be legally shared and which parts she need not divulge. Previously, she may have not proceeded with the application process past this point, but with the counsel and encouragement of the case management sessions, she will hopefully continue to actively pursue jobs.

Maintenance. The last phase of the change process is the maintenance phase, in which individuals build on gains attained during the action phase and work on preventing relapsing into past behavior. The role of the case manager continues to be a consultant, but in a much reduced

capacity (Norcross et al., 2010). The client feels more confident about her behavior and experiences greater autonomy. If all of the client's goals have been met—in this case, job and housing security—this might be the time to discuss termination and discharge planning. In other instances, it may be the moment to address other issues more closely, such as raising the client's education level for a more economically secure future.

Motivational intervening and the transtheoretical model address both the process and the action involved in changing behavior (Miller & Rollick, 2013; Norcross et al., 2010). They assert that the relational stance and accompanying intervention principles must be attuned to the client. An assessment process accompanied by thoughtful, sequenced intervention lays the foundation for delivering services in a conscious and trauma-informed manner. To help one understand where the client is in the change process, the University Rhode Island Change Assessment (URICA; Appendix D) is a scientifically sound tool that can help the case manager assess the attitudes and activities related to desired change. The URICA includes separate assessment scales for drug and alcohol abuse as well as one for psychotherapy. For general purposes and case management sessions, adapting the scale for psychotherapy and relating the responses to the desired goal would be the best fit.

The URICA is a 32-question survey that rates responses based on agreement or disagreement with the question posed. The scoring is divided into sub-scores that correspond to the five stages of change. The total tally of the sub-scores would reflect which stage the client's attitude and behaviors most reflect. (A sample of the tool and scoring instructions are included in the appendix of this manual.) Using the URICA can help the case manager clarify where the client is in relation to a specific goal and decide which relational stance and motivational interviewing style would be best approach for a mentioned goal.

Being prepared. Linkage and advocacy are critical roles for case managers. To appropriately match the client with the right services or to intervene on behalf of a client, the case manager must have a toolkit of internal and external resources. The more prepared and well versed case managers are in internal and external resources, the more they will be able to help provide crucial crisis management services. For internal resources, the case manager must have a well-organized resource book that includes a contact list with accompanying handouts for the major areas that case management sessions will typically cover. These include housing, employment, education, public assistance, parenting, domestic violence, substance abuse, and mental health services. For each topic, if possible, having a single point of contact for addressing each need and clear instructions on how to access the resource is optimal. Regularly updating the list of providers and their contact information so that clients do not get the runaround on services is also critical.

To link clients to outside services, a case manager should have firsthand knowledge of the corresponding service provider. As already discussed, this means that on-site visits to service providers and being visible in the social-service arena are expected. For example, a shelter case manager should know and have seen subsidized housing offered in the community. By visiting the housing site, the case manager can acquire firsthand knowledge about the complex and be able to answer any related questions. A site visit also creates an opportunity to build a working relationship with the housing management. Being an ally to the housing unit will help the case manager better prepare the clients to apply for housing. The visit will also prepare the case manager to be familiar with the personnel his or her clients will come into contact with so the case manager can also be an advocate, depending on the need and person. More generally, being visible will help the case manager access emerging resources.

By the same token, if possible, have qualified and quality service providers come to the shelter or agency to provide services. Transportation is a significant barrier to homeless women, and bringing service providers to shelter can help address this need. Enhancing internal resources also means developing and incorporating services within the agency. This includes running relevant groups such as substance abuse or parenting groups, and developing skill-enhancing classes on topics like financial planning or nutrition courses. Each class is an opportunity to engage community partners, such as the local health department or nurse-family partnership, in providing curriculum and qualified practitioners and resources. Being prepared by having responsive and adaptive services is necessary in crisis, because it builds the critical component of safety into trauma-informed services.

Knowledge areas. Linkage and advocacy services require strong knowledge of resources and an understanding of service need. Homeless women have expressed that they need help in accessing health and human services, education and employment, parenting and childcare resources, and (for some) help with domestic violence problems (GAO, 2010). Each of these areas is related to other issues that the case manager should be aware of and ready to respond to. The Resources section, located in Appendix J of this curriculum, will also provide information on resources that can address the domains mentioned.

"Health and human services" comprises services in major areas of life such as social welfare, education, mental health, housing, and other forms of health care. This is a very broad category, and a case manager does not need to know everything about all aspects of this domain. However, homeless women need help identifying and accessing available resources. This means the case manager should know about \the major service providers in the area and be familiar with the process required to receive services.

Since homelessness is an issue of precarious housing and poor resources, the case manager should know about subsidized and public housing and the application process for securing it. Most such facilities require applicants to submit information on their criminal and financial history. Thus, a case manager should also have a good working knowledge of renters' rights (which may vary quite widely county to county and state to state) and a grasp of financial literacy. Having a working knowledge of legal rights of tenants and being aware of the difference between misdemeanor and felony as it pertains to application to public services is critical.

Financial literacy entails knowing the basics of a credit report and understanding assesses and liabilities. Service providers will routinely ask clients to about these areas, and the homeless women the agency serves will need to be equipped to respond to such questions. Many women I have worked with are mystified by the housing application process and often feel that it is luck or being favored, as opposed to specific criteria, that make them eligible for services.

For educational and employment-related issues, it is likewise important to know the career and educational resources available in the community. Securing a job involves having a suitable resume, appropriate attire, and adequate interviewing skills. Often, there are resources and community groups that help address this need. If there are not, the shelter can provide this service internally. At a minimum this requires having an accessible internet-connected computer and a printer, a closet equipped with varying sizes of clothes and shoes, and coaching on interviewing skills.

Many homeless women share a desire to be upwardly mobile and to secure quality jobs. They know that education is a part of that process and want access to it. As a service provider, a case manager should know the application process for local GED and post-secondary educational programs. This involves knowing about financial aid, college application, and how to resolve

delinquent accounts. Some women may have borrowed money and started school but have then dropped out and are delinquent, unable to qualify for future loans without addressing the delinquency. They often feel doomed to stay in this condition, but knowledge of the appeals process and advocacy skills can help them begin moving beyond those barriers.

As to parenting, the central issues are access to reliable transportation and affordable day care. These are universal concerns for mothers, and a shelter provider for transitionally homeless mothers must plan to address this need. Most homeless women qualify for public assistance, and for working mothers, child care is available. Some women come with services in place, while others need help navigating the public welfare and assistance office. Having a working knowledge of public assistance and a strong working relationship with the welfare office is ideal. Specific parenting skills and activities for children can be addressed via parenting groups and connecting with after-school programs or mentoring groups. Again, knowing these resources and working closely with community providers will help clients meet their needs in this area.

Domestic violence and violence against women in general are an enormously widespread problem for homeless women. Being informed about the dynamics of intimate or partner abuse, therefore, is crucial to providing responsive services and for being sensitive to client needs. For women coming directly from a domestic-violence shelter or from harmful relationships, assessing risk and creating a safety plan are essential. This can be done in conjunction with domestic-violence service providers and advocates, who can often help with legal matters and with other forms of support. They also provide free training or psycho-educational programming that would be worth investigating.

Lastly, service providers should have working knowledge of how to manage stress and deal with grief and loss. These issues are central to helping homeless women cope with crisis and

become stable. Mental-health and substance-abuse service providers are equipped to help the women navigate their emotional turmoil. Knowing specific service providers and details of the program or service provided (like the therapeutic or treatment approach) will help identify fit between client and provider.

Format of sessions. Case management sessions should have a predictable format for approaching the identified goal or topic. Sessions that are predictable and sequenced can help anchor the client and foster feelings of safety. It is critical after the assessment session to set up a service plan so that there is a tangible stabilizing tool the client can reference. That said, having a service plan does not necessarily mean the client is in the action stage of change, let alone that there should be immediate action. In fact, in some instances, the service plan may only deal with stabilization or crisis management. This is often the case with women who are coming from domestic violence shelters or coming directly from the streets to shelter. Although they are homeless, they are typically not immediately prepared to work on a housing plan. Instead, they must focus on getting their basic needs met. Women in domestic violence situations must work on maintaining their physical safety and managing their internal stress, which often includes PTSD symptoms.

Regardless of the situation that led to the client entering the shelter system, one aspect of case management services will remain the same: *Service must start with what the client identifies as her most pressing area of need*. Although this sounds simple and is the priority of most service providers, it can be difficult to do when the client and the provider have conflicting views of what is most immediately essential. For instance, a client's goal may be repairing a relationship with a significant other or sending money to a family member. In the first case, the case manager may want to direct the client to focus on his or her own stability; in the second

case, the manager may attempt to discourage her from giving away her own limited funds. However, doing this is antithetical to the principle of letting the client determine the goal, especially at the beginning. Instead, the case manager must use reflective listening skills to understand the client's goals and help her meet her needs.

After determining goals, the client and case manager can decide which goal to address in the subsequent meetings. The sessions should be formatted to begin with checking in and spending some time getting updates on what is going on with the client. After checking in, the case manager should share the agreed goal and objectives of the session based on the prior meeting, and ask the client if that goal is still relevant and something she wants to pursue. Asking permission and giving choice is a critical component of trauma-informed service delivery, because it helps the client feel respected. If the client wants to continue with the agenda, the case manager will address the area of need and explore solutions to the problem. This begins by assessing the need, understanding in what ways meeting the need was attempted previously, and determining the appropriate next steps and the accompanying relational stance the case manager should assume.

This requires the case manager to be aware of any trauma related to meeting the goal. For instance, if the client shares that she was attacked near a building in the vicinity of where a critical service is provided (such as a public school or government building) the case manager should initiate a discussion of how the client's stress reactions might influence their behavior. In this case the client may become hypervigilant or dissociative when attempting to access the service and may need many small steps to achieve the goal. If the service is critical to her survival, the case manager may need to accompany the client to the service provider or attempt to access the needed service on the client's behalf.

After determining the goal and the steps needed to meet various aspects of the goal, the case manager and the client outline actions to be completed for the following session: the tasks the client and the manager respectively will each be responsible for. As with the check-in when starting the session, there will be a check-out, in which the case manager will summarize the agreed-upon action plan and establish the date for the next session. It is best if the client leaves with a handout of the summary and plans for each session so she has something in writing to help her remember the goals. The following sections use the outline session plan to address specific areas of case management sessions. They will address typical issues to be aware of in each session and will outline the appropriate relational stance and intervention.

To summarize, all sessions after the initial one should use the following format:

1. Check in.
2. Discuss what topic will be addressed in this session.
3. Work on issues related to the topic.
4. Determine the next set of steps and who and what will be involved in executing the steps.
5. Summarize the session.
6. Check out by scheduling a follow-up and providing a written summary of the action steps agreed to for both client and case worker.

Health and human services. Accessing needed social services is a primary concern for transitionally homeless women. Personal experience from working in the field, as well as published research, demonstrates that providing support to address external and internal barriers to accessing health and human service needs is critical. Specifically, homeless women shared that they need help with:

- knowing where to get services,
- navigating fragmented service provision and complicated instructions,
- managing a hectic schedule, and
- managing burnout and stress.

Working through issues related to the topic can take many sessions and many steps, because change takes time and pacing the intervention is crucial to being trauma-informed. The format of the sessions, however, should remain consistent. The URICA assessment tool is useful for gauging the level of readiness for change for step 6 of the outlined session format. (The tool can be found in the appendix of this curriculum.) One can also assess how ready the client is to move to the next stage of change or action using two simple questions that ask the client to rate on scale of 1-10 how ready and confident she is to address the particular goal. A score of 7 or higher to both questions will indicate that she is ready to act. The block text within the session examples provides sample dialogues to demonstrate the language case managers can use to lead clients through the session.

This sample session outlines an approach to address accessing health and human service needs with a client. The most obvious and consistent service need for this population is accessing affordable housing, and thus it provides the scenario and script for this example. It should be noted, however, that a human-service need can be broadly defined by the caseworker and client; this session is merely a template for providing service.

Session format.

1. *Check in (5-10 minutes).*

2. *Review the objective of the session and ask if that is still the desired or needed focus.* You should use this time to remind the client of where the prior session had left off, and confirm the goals for the current session.

> *As we discussed in our last session, today we are going to be going over how you can access housing and discuss what resources and steps are available for you. It can seem like a daunting and overwhelming process, but I am here to help you. We will discuss what your needs are, how you have tried to get housing in the past, and come up with a plan together. How does that sound?*

3. *Review past attempts to meet the need and what traumatic or adverse experiences surround meeting the need*. Note from the Trauma Exposure Questionnaire any extremely distressing matters related to this need, or possibly a parallel experience. For instance, was there an eviction from housing or history of growing up in dangerous public housing?
4. *Ask the client about past experience with this issue:*

> *Can you tell me if you have tried to get housing in the past, and if so, what that experience was like for you? What went well, and what did not go so well?*

Take this time to take notes on the experiences mentioned, and if the client does not mention the past traumatic experience as an issue, bring it up as topic and ask how it might play a role in their current attempt to get services. Some women may not have considered the affect the past experience will have on them and will be caught off-guard when they are retriggered at the service site. Others may be actively avoiding it and may need to be helped to face it via some debriefing around it and getting some emotional support. For still others, it may be a resolved issue, and they may have strong coping structures to face it. This information cannot be uncovered unless it is directly asked for.

> *I remembered that from our assessment session that you mentioned that you were evicted from a housing unit and that it was difficult experience for you. When you think about trying to get housing again and your past experience what are some*

> *feelings that come up for you? What are the physical sensations you feel in your body or images that you have when you think about that experience?*

If she describes hypervilgilance or dissociative feelings associated with the experience, take note to plan on working through the emotions and stress reactions. The responses to this section will provide clues about the appropriate role the case manager should play: nurturing parent, Socratic teacher, coach, or consultant. You should take note of body reactions as the client speaks, and notice if she seems stressed or disconnected in her responses. She may not be aware that she is having this type of response and may feel she is fine, but her physical response may indicate otherwise. After she shares this, summarize what you heard her say and what you observed and ask if that is correct. This reflective listening skill will communicate engagement and receptivity to what is being said.

5. *Review resources, strengths, and cultural considerations in meeting the need*. This includes getting information on the formal and informal relationships, the level of support, and intensity of support. Some women are extremely adept at getting services, and may even be getting duplicate services that are wasting or straining their much-needed time. Other women feel completely overwhelmed or frustrated by fragmented services or feel intimidated by the providing institution such as housing services. Getting detailed information on resources will help better tailor services.

> *Can you tell me who from the community, your family, or friends has tried to help you with this matter in the past? What things did you find helpful and how much help did they give you?*

You should take notes on resources mentioned and the level of connection and frequency of contact. For instance, the client may mention that her friend or family member has helped her fill

out the applications in the past or helped her with her eviction. She may also discuss her attempt to get help regarding the eviction form legal services. This will help you decide which services and service providers are good fit for this client and what level of advocacy is needed. For instance, the client may have blown up at the legal-aid staffer or have shut down completely and will need a coach to navigate that relationship. During this time, cultural issues or values that are important to the client in getting this resource or need met should be discussed. This is critical, but often the last item discussed.

> *When you think about getting housing, what are some important things you want me to know or consider as they relates to your culture, upbringing, or race or ethnicity? For example, for some people living near their relatives is very important, while for others it is being in a child-friendly neighborhood. For someone else it may be that the area is welcoming to her religious or racial background. What are things about housing that are important to you?*

As the client responds, the case manager should note what she shares as important and consider the implication for the referrals or services.

6. *Discuss what internal and external barriers stand in the way of meeting this goal*. For many women, not knowing about or having good access to resources is the primary barrier. The question relating to past attempts to meet this need will be helpful in probing for more details in this area. Past criminal or financial mistakes are often barriers in completing applications for housing. Asking detailed questions about the areas mentioned will also help determine what kind of intervention should be provided:

> *Can you tell me about what things you think stand in the way of you getting housing? Do you have any criminal charges that you have been convicted of that*

> *you think would be a problem for your housing application? How about any money or back payment owed to housing services that might come up?*

Notes should document the client's response, and you should follow up with a question about how the client will manage her time and stress while addressing this need:

> *Getting housing is a complicated and stressful experience. Because of this, some people naturally feel stressed and are exhausted by the process. What do you think are some emotional obstacles or stressors that might affect your attempts? Do you think time management will be an issue for you?*

7. *Educate the client about how to access service, and providing specific steps that must be taken*. At this time, you should determine the client's level of motivation along with her current state of change so as to evaluate how prepared she is to engage in accessing the service. This will help determine the appropriate relational stance and which intervention techniques would be most useful. If the client's level or readiness behavior is unclear, the University of Rhone Island Change Assessment scale (URICA) can be useful. A tally of scores on the instrument will provide a summary of the client's current readiness and provide clues for how to be most helpful moving forward.

If the client is in pre-contemplation or contemplation, service-giving or active planning in engaging with service providers is not helpful and may overwhelm her or set her up for failure. It is better to continue to engage in the steps outlined in 2. and 3. above: it may be necessary to work on distress and emotional management, or on building strengths and resources. As this process continues, you can do a simple assessment by asking her to rate how ready she is to move to the preparation stage and how confident she feels to move to the planning stage. She can rank her response on a scale of 1-10. A score of 7 or higher on both "feeling prepared" and

"feeling confident" will indicate that she is prepared to move on; lower scores will indicate that she is needs to do some more work first.

If the client is in the preparation stage, being a coach is the most active and directive involvement. You should be prepared with specific contacts at each agency or be aware of how services are delivered and ready to discuss in detail each step the client will need to take to access the service. These include how she will get to the service provider and how she will manage a challenging situation. These discussions will build safety and help the client manage distressing events. You should be sure to express hope and confidence, so the client feels that she has an ally. Roleplaying conversations with the client can help her practice self-advocacy and how to engage in a prosocial manner.

In the action phase, the client will be actively meeting with providers and updating you on her progress. As a consultant, you should ask her specific questions about her interactions and debrief with her after each meeting. That way you can have first-hand knowledge of her experience and determine whether additional services are needed. For instance, the client returns from a meeting with a housing provider and tells you her criminal history precludes her from applying and qualifying for that housing unit. In this case, you point out that the client always has the right to apply and discuss what part of her criminal history she is mandated to divulge. You and the client can determine as a team whether the client should go back to the provider and refill the application, or whether you should ask the housing provider for a copy of the application and then fill it out in your office together with the client. These interactions will relay that you are her ally and help her build connections to the community.

In the maintenance stage, the client may have taken all the right steps to access the service, and all she then needs is encouragement to follow up on her progress and to stay hopeful.

If that is the case, monitoring the progress of each process and determine what to do when you reach each goal will help build resiliency. In this phase, you might also encourage her to share her experiences with other women in the shelter as a way to support and empower one another.

8. *Determine what steps need to be taken and establish what the case manager will do and what client will do*. In the initial stages, this may be as simple as continuing talk about past attempts at accessing housing because the client has a complicated history or became overwhelmed talking about it. Alternatively, if she is in the preparation or action stage, these steps may be very a detailed plan.

9. *Summarize the sessions and reiterate and where you think she is and what the next session will entail*. Prior to closing the session, the case manager should take a few moments to review the major points of the session, and plan for the next meeting.

> *So today we talked about your past experiences in trying to get housing. I'm hearing that you have been able to get housing in the past, but your eviction due to domestic violence was really difficult. It sounds like you are not quite ready to start looking at housing options yet. So, we've agreed that we will continue talking about your past experience, and for the next session we'll talk about what supports you have in the community. You will not need to prepare or do anything for the next session. I will get you the bus vouchers and have them ready for you for the next session. How does this sound?*

10. *Check out by saying goodbye.*

Education and employment. The structure of sessions focusing on education and employment is much like that of the health and human services example, but the focus of the sessions is adjusted to the unique education and employment needs of the client. Concerning

education and employment, homeless women shared the following problems as their barriers to addressing their education and employment goals:

- Lack of information on how to apply for and receive financial assistance
- Desire to attend more school but it seems like a luxury item compared to their daily struggle to survive
- Loss of funding to educational training programs
- Lack of or need to access community resources for career development

The sessions designed to address these challenges should follow the patterned format below:

1. Check-in.
2. Review the objective of the session.
3. Review past attempts to meet the need.
4. Review resources, strengths, and cultural considerations.
5. Review external and internal barriers.
6. Determine the steps that need to be taken.
7. Determine roles and responsibilities.
8. Summarize the session and set up follow up session.
9. Check-out.

Working through issues related to this topic can take many sessions and many steps, because change takes time and pacing the intervention is crucial to being trauma-informed. The format of the sessions, however, should remain consistent. The URICA assessment tool is useful for gagging the level of readiness for change for step 6 of the outlined session format. (The tool can be found in the appendix of this curriculum.) One can also assess how ready the client is to move to next stage of change or action using two simple questions that ask the client to rate on scale of

1-10 how ready and confident she is to address the particular goal. A score of 7 or higher to both questions will indicate that she is ready to act. The block text within the session examples provides sample dialogues to demonstrate the language case managers can use to lead clients through the session.

Session format.

1. *Check in (5-10 minutes).*
2. *Review the session objective and ask if the topic (education/employment) is still the focus*. You should use this time to remind the client of where the prior session had left off and to confirm the goals for the current session.

> *Today we are going to be talking about your desire to get your Certified Nurse Assistant credential. I know being a nurse is a dream of yours and that you want to try out being a CNA to see if the medical field is the right choice for you. We will discuss your educational goals and history and decide what steps you want to take to meet your goal. How does that sound?*

3. *Review past attempts to meet the need and the traumatic or adverse experiences surrounding the topic*. You should note from the trauma exposure questionnaire if there are any matters that she mentioned that are worth noting. For instance, what was her schooling or employment experience like? Does she have any delinquent student loans, or is she enrolled in predatory or discontinued programs?

> *Please tell me about your past attempts at getting your CNA certification as well as your attempts to get more educational in general. Was it a positive or negative experience? Can you say more about that?*

You should take notes on experiences she shares. Educational institutions are very intimidating, and women of minority status often report feeling discriminated against or alienated in the

classroom. Online school programs have also targeted low-income students and provided access to large loans but often with high tuition and poor-quality educational programming. This may cause the student to drop out after incurring large student loan debt that becomes delinquent, thus impeding her future attempts to access education. Poor educational supports may cause her to internalize her failure and may retrigger past feelings of inadequacy and despair. These feelings need to be brought up and explored so the client does not enter another educational setting and then repeat the pattern and feel even more like a failure.

> *I remember from our first couple of sessions that you mentioned that you had tried to get your certification though your work. You said that didn't work out because of scheduling problems so you thought you would try the classes on-line— but that was even worse, and now you have a large debt. How are you feeling now about revisiting getting your certification?*

It is important for you to take the time to reflectively listen and understand the client's stress response to the current situation. The responses to this section will indicate whether the client is in need of a nurturing parent, a Socratic teacher, a coach, or a consultant. You should summarize what is said and share observations as the client is describing her feelings:

> *I heard you say that you were initially very excited about getting your education and thought the online program would be really good. When it didn't work out, it was really hard on you and you felt that maybe this was too big of a dream or that you were not smart enough. So it makes sense to me that you are nervous about starting this process, and when I see your tears, it shows me how much this means to you.*

A reflective response, such as the one above, demonstrates that the case manager is listening empathically and compassionately.

4. *Review resources, strengths, and cultural considerations in meeting this need*. This includes getting information on formal and informal supports and understanding the strength and frequency of the provided support.

> *Can you tell me what supports or strengths you have to help you get your certification/education? Has anybody tried to help you with this in the past? What specific things did you find helpful?*

You should take notes on the resources mentioned and ask the client about reliable transportation and safe reliable care-givers to watch children if necessary. Her responses will help guide planning for the preparation and action stage of change.

You should also discuss what cultural values are worth considering in pursuing this goal. Some cultures value education and speak highly of it but can be disparaging to the person getting more education because she is perceived as an outsider who is trying to escape her culture or norm. For mothers, pursuing education can feel selfish or like a luxury, because it focuses on the mother as opposed to the child, and some mothers struggle with feelings of guilt. These cultural issues must be examined and considered.

> *When you think about going back to school, what are some important things from your upbringing or culture or ethnicity that you think would be helpful or problematic in you reaching your goals?*

Reflectively listening to what the client shares and considering the implications of the responses will guide the case manager in making appropriate referrals and recommending services.

5. Discuss what internal and external barriers stand in the way of meeting this goal. Ask if she as a computer, a resume, school supplies, reliable transportation, and safe reliable caregivers to watch the kids while she is in school. Her responses will help guide planning for

the preparation and action stage of change. You should also encourage the student to consider *stress* and how stress will be managed as she takes on new responsibilities with work or school.

> *Getting an education can be very taxing on your schedule. Because of this, some people understandably get stressed and exhausted. What do you think are some emotional obstacles or stressors that might affect this goal? How do you normally handle time management problems?*

Encouraging the client to consider these issues in advance can help you and the client understand her coping strategy and her response to increased stress. Most women must work to get educational assistance from assistance office, and this can be distressing to them. Working while being a student is a stressful experience by itself, and the stress is compounded by precarious housing status. On the other hand, the shelter offers stability, safety, and access to supportive resources including you as case manager. Helping women improve their economic conditions through education and good-quality jobs empowers them to attain and sustain stability.

6. *Educate the client on how to access service and be specific about the steps that need to be taken*. You will need to provide basic information on what educational or employment institutions are available, what is required to access or participate their resources, and what steps need to be taken to begin that process. For instance, there may be a vocational college that offers a certification program such as CNA program that is intensive, short-duration, and free of charge for those who qualify. This might seem a good fit for the example client, but she may be overwhelmed by the intensivity of the program and would do better with more traditional options. Knowing multiple resources and offering alternatives encourages autonomy and gives the client choices, reflecting trauma-informed principles.

After sharing the information, you will need to determine the client's level of motivation and what stage of change she is in so as to understand how prepared she is to engage in meeting

the stated goal. Understating the relational stance one should engage in will help determine appropriate intervention. If her readiness level is unclear, the University of Rhone Island Change Assessment (URICA) scale can be a useful tool (see Appendix D).

An assessment of preparedness and confidence for change can be accomplished using the simple assessment technique of asking the client to rate how ready she is to address this goal and how confident she feels about meeting this goal. She can rank her response on a scale of 1-10. A score of 7 or higher on both feeling prepared and confident will indicate that she is prepared to move on. Lower scores will indicate that she needs help increasing her confidence and supports.

Pursuing education or employment opportunity is a multi-layered process that requires navigating through prescribed steps, using certain social skills. This means the client must be equipped to handle the situation she is facing and to manage her own feelings. Thus, preparing the client to face these institutions is very important. Your stance in the helping process will help the client gain the skills to negotiate through the institution, and successful interactions will build her self-esteem.

The shelter or agency can get the client thinking about her educational or employment prospects by inviting speakers from employment or educational agencies to speak on-site. This can generate interest in the topic among those who may not be immediately interested in pursuing education or employment. As a matter of policy, some agencies may be required to dedicate at least one case management session or conversation to this topic. You should take this time to explore the client's stance and to gauge how interested they are or how important this topic is to her. This is essentially the preconception stage, and hearing the client's responses to the general presentation of resources available will indicate her level of interest. Assistance with these goals can be offered when she is ready.

In the contemplation stage, the client is likely to be considering applying for programs or a particular job. She may mention she is thinking about a certain program or a particular job, but discusses more of the barriers of attaining the goals. She may also express doubts about her ability to manage the stress and navigate the process. These concerns are legitimate, and some aspects of them may be tied to her past trauma. Your stance in this instance is one of a nurturing parent. Reflective listening and expressing empathy for the difficulty of attaining the goal will communicate that her concerns are heard and that they are legitimate.

It is important that you do not try to coerce or convince her to take action. She may agree to do things because she wants to please you and not because she is ready. You can sketch a decisional balance tree in which you discuss the pros and cons of pursuing the goal to help her better clarify what she wants. This may be to not attend school at this time, or to apply for a better paying job. Regardless, the choice must be hers.

> *It sounds like you are not quite sure if you are ready to go to school yet and you worry about how much time it would take and if you are ready for it. You also shared that you worry that if you do not do this that you will be stuck in low paying jobs and might end up back at the shelter. These are legitimate concerns and it makes sense for you to really think through your decision. Would it be helpful to you if we took some time to discuss what are the positive and negative aspects of going to school? We can write it out the on a piece paper. Getting it on paper helps clarify what is running around in your head and you can use it refer to later. How does this sound?*

You should continue to engage in reflective listening and helping her clarify her choice, expressing empathy, confidence, and continuous support. This will increase her confidence level and help her come to the preparation stage.

In the preparation stage, the client will be engaging in change talk and will have high motivation. In some cases, she may overestimate her skills and preparedness because the motivation is so high. This may prompt her to pursue the goal prematurely and then not do well because she was ill-prepared. This is harmful because it may reinforce negative assumptions and repeat past trauma. To avoid this, a coaching stance will help her come up with a detailed plan to navigate to the goal.

Preparation entails having knowledge of the resource and being prepared to engage with the resource. The knowledge comes from both you and the client. It is disempowering to assume that you are the sole authority on the subject. Using gathered information from assessments on barriers and strength, you and the client can tailor a service plan. The plan would be cognizant of the client's past experience and current coping skills. Having the accurate paperwork or other materials is the best linkage role that you can take. This means gaining access to application materials and/or having the skill set to coach the client in writing and developing a strong resume.

Coaching should include roleplaying likely interactions with education staff or employers. Practicing how to navigate through a system will help the client feel more confident in her skills and develop healthier responses to stress. Some women are extremely adept at navigating informal systems and have high social skills. However, this may not translate in their interactions with formal systems because they may shut down or come off as aggressive. Their assertiveness may have helped them survive in their past, but it may be read as hostile in other situations. Working through roleplaying and understanding your client's coping styles, you can help prepare them for successful interactions with formal systems that will increase their confidence.

Coaching sessions can also prepare the client to face challenges because they will practice responding to several scenarios. Below is an example of a coaching session that examines potential challenges.

> *So we have role-played what you will say to the admissions person at the college to get a copy of the application and find out where you can go to fill out your financial aid papers. I think you will do a great job and you have some good questions prepared. But we also need to make sure that you are ready for some surprises. For instance, what do you think you will do if you get there and find out the person you were scheduled to meet with is out for the day? Or what about if they have moved offices or the application process is all on computers? How do you think you will feel, and then how do to think you can respond to these changes?*

The above scenario is an example of working through foreseeable challenges and preparing the client to face multiple scenarios. The client may think it is unnecessary to go into so many details, but it is better to be overprepared than to be surprised or self-sabotaged. In some cases, even approaching the institution may be intimidating, so the case manager may need to consider going with the client to see the institution and work on-site on managing stress levels.

This last should be a careful decision made jointly by you and the client. There is a tendency for case managers to rescue clients or do things for them that they are capable of handling on their own. Knowing the client's temperament and moving carefully through the contemplation stage will help you know how to handle the preparation stage. The preparation stage is a collaborative process that will facilitate the best outcomes for action stage.

In the action stage, the client is actively be pursuing education and/or employment. As a consultant, you let the client navigate and engage with the various systems and be the safe place to process the interactions. Working through the action steps and processing interactions will

allow the client to reconstruct past traumatic experiences and provide new narratives. This reconstruction is delicate. Some women may not feel they deserve success and may subconsciously begin self-sabotaging. As a consultant, you can help anchor the client and bring light to the process.

For instance, the client may think that her instructor is unresponsive or targeting her in class, and as a result, she starts being tardy or missing class altogether. In this case, you should point out the discrepancy between the behavior and client's stated desire. This can also be a time to explore how past traumatic experiences can continue to influence behavior even in successful times.

> *I have been so impressed by how hard you've been working to get into your program and how much effort you've put into your studies. I have noticed that you missed a couple of classes and heard you say that you don't think your teacher cares about you. You also mentioned that when you feel like you're putting in lots of effort and it seems that nobody cares about that, it makes you want to just pack up and go. I know that this program means so much to you and when you miss classes it seems like you are not as interested in the program. I know that it was your hope to complete the program—has that changed for you?*

This approach takes into account the noted difference in the behavior while mentioning a stress response as a possible explanation. By not blaming or confronting, you have given the client the opportunity to reflect on her actions. Continuing to work on the action plan and revising it as needed creates a responsive service plan.

In the maintenance stage, the client is progressing toward her goal, and you continues in your role as encourager so as to build the client's capacity. Maintaining goal-oriented behavior can be difficult. Surprisingly, for some trauma survivors, stability generates anxiety or discomfort because it feels so different, or because it feels as though they are waiting for the

bottom to fall out. Instilling hope and informing the client that she will have setbacks but that she can get back on track is part of maintenance on your part as her case manager; this removes the pressure of having to be "perfect."

Preparing the client for the last stage of meeting the goal often entails encouraging her to become the leader in her new role. This will help her to strengthen her sense of purpose and feel connected to her surroundings. For a client to make meaning of her experience and translate that into positive connection is an important trauma-informed principle. about the ultimate goal is not just overcoming a barrier but emerging on the other side and growing.

7. *Determine what steps you need to take as case manager and what steps need to be taken by the client*. In the initial stages, you may do most of the work by proving education and linkage services. In the action-oriented stage, the client tends to make more of the steps. What is important in all stages of intervention is that both your roles are clearly defined and there is follow-up on each action plan.

8. *Summarize what occurred at the end of each session and restate the roles of each person for the upcoming session*. This will build predictability and promote safety because the client will always know what to expect and what is expected from them.

> *Today we talked about how you felt about missing classes and determined that you were doing that because it was stressing you out to think that the teacher did not like you, and not because you were not interested in going to class. We talked about how you might feel more comfortable in the class if you had a friend there. You mentioned that you thought Maria in your class was nice and that you would ask her to be your study partner. We role-played some ways you might approach Maria, and you decided you would start by saying hello to her before class and seeing if you can sit next to her. You will try that for your next class and we will discuss how that went. We also discussed that you needed school supplies and*

that you had run out of money to buy them. Let's walk over to the resource closet and see if we can find some of the things you need. If we do not have the items, I will talk to our team about restocking and see if I can get back to you about it tomorrow. Would it be okay for me to stop by your room after 10:00 am to check back with you?

10. *Check out by saying goodbye*.

Parenting. Issues related to accessing resources as a single parent or regarding parenting itself are particularly sensitive. Homeless mothers express tremendous guilt about being homeless and have the compounded stress of taking care of themselves and their vulnerable children. (Most single homeless women have adult children or do not have current custody of their children.) Many mothers share that were raised by a single mother and feel ill equipped to manage their parental roles. The two most salient barriers that homeless mothers face are the lack of reliable and affordable childcare, and transportation. They also shared the following items as barriers:

- Activities for their children's education and development
- Cultural differences in parenting styles
- Poor parental role models
- Poor communication and parenting of their own children

This session will focus on how to address issues related to panting and will use accessing childcare as the session sample. The sessions designed to address these challenges should follow a patterned format outlined below:

1. Check-in.
2. Review the objective of the session.

3. Review past attempts to meet the need.
4. Review resources, strengths, and cultural considerations.
5. Review external and internal barriers.
6. Determine the steps that need to be taken.
7. Determine roles and responsibilities.
8. Summarize the session and set up follow up session.
9. Check-out.

Working through issues related to this topic can take many sessions and many steps, because change takes time and pacing the intervention is crucial to being trauma-informed. The format of the sessions, however, should remain consistent. The URICA assessment tool is useful for gagging the level of readiness for change for step 6 of the outlined session format. (The tool can be found in the appendix of this curriculum.) One can also assess how ready the client is to move to next stage of change or action using two simple questions that ask the client to rate on scale of 1-10 how ready and confident she is to address the particular goal. A score of 7 or higher to both questions will indicate that she is ready to act. The block text within the session examples provides sample dialogues to demonstrate the language case managers can use to lead clients through the session.

Session format.

1. *Check in (5-10 minutes).*
2. *Review the session objective and ask if the topic (parenting and childcare) is still the focus*.

You should review the objective agreed on during the last session and ask if the topic, parenting-related issues, is still what the client would like to discuss. Asking this allows the client to decide

whether the set agenda still meets her needs, and more generally gives her a chance to choose. These interactions promote autonomy and choice which are values of trauma-informed services. An example of such dialogue is below.

> *Today we are going to be talking about some issues related to parenting. Specifically, we will be discussing how you can start getting daycare service. I know you have been worried about finding about a place that will take welfare vouchers. We can talk through what is important to you, what you tried in the past, and what is available. Is this still something that you want to talk about today?*

The most salient issues related to parenting are finding reliable and affordable daycare and transportation. Shelter workers would often prefer to discuss parenting style as a primary issue, because it can be safety-related, or because it may create more stability for the vulnerable children. However, for most women finding childcare so as to pursue work is the most pressing concern. Sessions on specific parenting techniques can also be conducted, but the topic will need to be approached in strategic way, preferably brought up by the mother, because mothers are highly sensitive to intrusions on their parenting style. The shelter should have an explicit policy on how to address abuse or neglect issues and share that with the mothers at the time of entry. Most shelters do not allow corporal discipline and must inform the mothers of this and offer sessions on parenting as a means of support.

3. *Review past attempts to meet this need and include a discussion of any related traumatic or adverse life experiences from the trauma exposure questionnaire*. How a client was parented and raised plays a significant role in her coping strategy as well in as her own parenting style. Being a single parent or a parent who is separated from a significant other is a difficult experience. Many women in the shelter have experiences of being raised by single parent. Their histories may be a positive, resilience-building experience, or they may have experienced a difficult or

trauma-filled early life. These early experiences shape how the adult mothers think about themselves and their own children. It is critical to review not just whether and how they have tried to access services but also on how their past informs the way they pursue the resource.

For instance, mothers with a history of being abused or neglected as children as may assume that simply finding a reliable caregiver for while they are at work is the only issue they should consider when looking for one. They may not be aware that the caregiver's *quality* of care is as important as that caregiver's reliability because their efforts just to find consistent care are much more responsible than what they grew up with. It is in reviewing their past attempts to access a resource, as well as what was modeled to them, that you can come to understand what considerations should be included in the steps of service plan. Below is an example of asking about past attempts to get a resource:

> *Can you tell me about what you have tried to do to get daycare in the past? Was it a positive or negative experience? I remember from our first sessions that you mentioned that when you were growing up, your parents often left you with strangers when they had to go out and that eventually Child Protective Services was contacted. What was that experience like, and how do you think it affects you when you think about getting caregivers for your children?*

The case manager should take the time to reflectively listen to the client's response so as to understand of how her own caregiving is influenced by her past. This will let you know how much education or information may need to be provided. In this case, the client may share that she has used her mother as a caregiver for her own children because she was the only resource available and because she believes her mother has changed for the better. The next step of the session involves reviewing resources and strengths. In this phase, you may be able to discuss in detail whether the client's mother is actually a reliable resource.

4. *Review resources, strengths, and cultural considerations in meeting this need*. This step entails getting information on the informal and formal supports and understanding their intensity and frequency. Some mothers have a cluster of formal and informal supports, while others are isolated or have a single support. In this review process, the case manager can get a sense of who and what the children are exposed to and evaluate the safety of the environments.

In this process, it is important for the case manager to use reflective listening skills to build a working alliance and avoid seeming like an investigator. It may make the client defensive if she feels as if this is an interrogation. On the other hand, some clients may have had a succession of institutional and private childcare providers in their lives and hence have become desensitized to intrusive or inappropriate questions. Being a trauma-informed provider aims to avoid or repeat examples of both experiences. Below is an example of how to ask about supports:

> *I want to understand who has been helpful to you with child-care in the past so we can determine how much if any help they can give you now. Can you tell me who in the past and even now helps with you child care? Who do you rely the most on and how much help do they give you?*

The case manager should take notes on the resources mentioned and keep them in mind when creating the service plan. In the current example, the client might share that she keeps her children at her mother's, and that her mother has a new significant other living with her almost every day of the week. She may share that her mother is reliable and that her new boyfriend seems nice, but that she does not know him too well. The case manager should avoid the temptation to offer advice or take over at this point. This is still the assessment process and reflectively listening will build safety. A example of a reflective response might include:

> *It sounds like you rely on your mother for help and that you don't really have strong feelings about her boyfriend because you don't know him that well.*

Discussing values or cultural experiences is important in pursuing this goal. However, cultural considerations in accessing services may not play as significant a role as parenting technique or style. By contrast, when discussing parenting style, cultural values and consideration are especially important. What you may see as poor parenting or harsh discipline maybe culturally sanctioned practice for that client. For example, in some cultures children are permitted to voice their opinions, and while in other cultures, it seen as a sign of disrespect toward the parent.

In a similar scenario, you may witness a parent-child interaction in which the parent is constantly giving directions to the child and may conclude that the child does not have a voice in the family. That may or may not be the case, but it must be explored with the parent. You can ask general questions about what is culturally important to the parent or inquire about what cultural practices from their past play a role in their parenting:

> *Can you tell me some things from your upbringing or background that are important to you about the kind of childcare setting or provider that you want us to consider when we are looking for daycare providers? For instance, for some people having daycare that is with a certain religious group is important to them. For others it is important that the care-giver does not spank to discipline the children.*

The case manager should reflectively listen to what is shared and consider the implications of the information on the referrals and services they provide. However, these contextual issues should influence interventions and should not be viewed as information only.

5. *Review external and internal barriers that stand in the way of meeting this goal*.

Transportation and availability and access to daycare are the most cited external need for homeless mothers. This issue is even more pronounced in rural regions where public

transportation is unavailable or limited. Consequently this is also where advocacy and linkage services are most valuable. The shelter must have a responsive strategy to address this need and not simply cite lack of resources as a reason not to do so. Some shelter providers, for example, operate daycare centers as part of the shelter. The daycare generates revenue, employs the women in the shelter, and provides care for the children. In other cases, an agency might have an agreement with daycare center to provide care for the children at the shelter.

This is also the time to reconsider caregivers that may not be suitable. For instance, some women have multiple caregivers throughout the week for their children. Although this sort of arrangement provides a basic level of care, it is not in the best interest of the children to be around so many different caregivers. Cultural issues might also come into play in these instances. In some cultures, the definition of family is not limited to nuclear family, and thus any family member who is kin or in some cases fictive-kin—people who are considered family members but are not actually related—are considered safe (Brown, Cohen, & Wheeler, 2002). In these cases, what might look like multiple providers to you may be just family members from the client perspective. But even with a fluid definition of family, a culture may still consider only certain people appropriate for caregiving and others only for affiliation (Hegar, 1999).

Internal barriers that homeless women face include the stress of a being single parent and having suitable parenting skills and activities for the children. Many women struggle with guilt about having their children in a shelter and feel that they personally failed their children. There is stigma associated with living in transitional housing, and yet it might be the safest place the client and her children have lived in for a long time. These are complicated feelings that need to be processed as part of the service provision. For instance, some mothers might be so embarrassed that they are living in a shelter or their children might be so affected, that they may

pursue their goals over- aggressively or in some cases seem ungrateful because they are disparaging of the shelter. These feelings are understandable, and clients need a tolerant and safe space to navigate them. Internal support groups for mothers are a place to process these emotions and get support from people who have been through this process.

6. *Determine what steps need to be taken*. To determine the appropriate steps, you should be aware of the stage of change the client is in and how prepared she is to pursue the goal. The first step is to educate the client on the aspects of the needed service, and the second to establish the steps she will need to take to access the resource. Understanding her level of motivation and preparedness will inform the relational stance you should assume: nurturing parent, Socratic teacher, coach, or consultant. If you're unsure about the client's stage level to engage in change, the University of Rhode Island Change assessment (URICA) scale (Appendix D) can be utilized. The score can help determine which stage of change the client is engaged in.

There is another useful but very simple assessment process that gauges how prepared and confident the client is. You can just ask the client to rate on scale of 1-10 how ready she is to address the goal, and how confident she feels about meeting the goal. A score of 7 or higher to both questions indicates that she is prepared to act on meeting the goal, while a lower score indicates that she needs help increasing her confidence and supports before acting.

If the client is in the pre-contemplation stage, she is not interested in pursuing services for parenting, so perhaps you initiated the conversation regarding the topic. This may be because case managers at your agency are required by policy to address the topic. Alternatively, you may have done so because there are concerns about a client's parenting style because it borders on abuse or is incompatible with agency policies, such as leaving the children unsupervised in her

room. In this phase, you can provide information or reiterate policy and offer services if the client needs help in complying.

In the contemplation stage, the client is considering applying for daycare programs or getting additional assistance with parenting techniques. She may also express more doubts about her ability to get services or her need for parenting help, to the point that she brings up more obstacles to addressing the problem than she pursues solutions. For example, she might say that it is useless even to apply for a daycare voucher because it is well known that there are long waiting lists and that there are no good services anyway. At the same time, she may express the concern that if she does not get more formal help, her mother might get tired of babysitting and then she would lose her job.

In this phase, your role is to be nurturing parent who is reflectively listening and helping the client clarify her goals. A decisional-balance process whereby there is a discussion of the pros and cons of pursuing the goal can help clarify which direction the client wants to move in. This process can be completed using a piece of paper that can then serve as a tangible tool to help the client think through her choice. This process and phase is noncoercive and gives the client the ability to choose what she ready for and when; this in turn builds safety and promotes trauma-informed care. Below is an example of reflective listening with an invitation to engage in decisional balance process in the contemplation phase.

> *So you have heard from others and even learned from your own experience in the past that the process of getting daycare is long and maybe not worth pursuing. But at the same time, you worry that your mother might change her mind about watching the children. Would it be helpful to you if we took some time to discuss what are the positive and negative things about applying for daycare services as opposed to continuing to rely on your mother?*

During this time, you should continue to engage in reflective listening while expressing empathy and confidence in the client and the collaborative process. This will increase the client's confidence level and help her get to the preparation stage.

In the preparation stage, the client will be expressing a strong desire to pursue the goal. The dialogue will be change-focused, and she will want to begin planning for action. In the preparation stage, you are the experienced coach who will provide detailed guidance. So that means the case manager will provide valid information on available resources and will help the client navigate through complicated or limited services.

In some instances, if the client lacks appropriate social skills, she may need to role-play how to approach the provider and ask for services. The role-plays can also include what to do if there are challenging or unforeseeable changes. Some clients may be retriggered or become dissociated when they come into contact with service providers and will need to address their fears through coaching and imaginative exercises. Below is an example of preparing to role-play for a challenging circumstance.

> *Today we will role-play what you will do when you go to the appointment at the daycare center you're interested and what you can do when unexpected things happen. You shared that in the past when you go places with a plan and there are surprises, you become really upset and tongue-tied and feel really embarrassed and end up running out of the place. I can see why experiences like that would make you nervous about going places to get help. To help you handle surprising situations, how would you feel about role-playing a couple of different challenging scenarios that may come up, so you can plan for the unexpected?*

If the topic is actual parenting, such as helping your client discipline the children, you should use culturally and developmentally appropriate interventions. This may first require helping the mother manage her own stress level before addressing her children. Coaching on parenting

techniques starts with providing information on how to develop consistent, predictable parenting. You can lead conversation and role-playing on how she will handle typical situations with her children, leading to a definite, written plan of action. Rehearsing and role-playing will help the client prepare for the action part of executing the plan.

In the action phase, you are a consultant and the client is actively achieving the goal. As a consultant, you provide advocacy and linkage services and offer a safe place for the client to discuss how she is progressing toward the goal. You can debrief the client after she has performed a specific task and talk about what went well and what she would like to continue working on. This collaborative approach will increase the client's self-esteem and capacity and continue to build on her working alliance with you. An example of reviewing a specific task in the action phase is below:

> *In our last session we discussed and role-played how you would go to the daycare center down the street. You were nervous about approaching the manager because she was rude to you in the past, but you decided to face her again. I have been so impressed by how hard you have been working, and I see your confidence growing. Can you tell me how it went when you to the daycare center?*

By asking an open-ended question, you allow the client to relate the experience from her perspective and do not assume it went either well or terribly; the client can share the experience and determine what it means to her. Creating a safe place to make meaning of the experience and to get needed support is reflective of a trauma-informed service delivery.

The last phase is the maintenance phase, in which the client is engaged in the goal regularly. Your role now is to be a consultant who monitors the goal and offers services as needed. This may entail simple checking in, such as asking how things are going at daycare. It may also be scheduled monitoring, where you may make a point of bringing up the topic.

Furthermore, one way to increasing one's self-sufficiency and self-esteem is by being altruistic or an advocate for others. Hence, you may ask the client to be a group leader or speak to others about her successful navigation so she can instill hope in other clients. Again, this promotes healing and provides services in trauma-informed manner.

7. *Determine the roles and responsibilities of each of you—yourself and the client—in executing a task or portion of the service plan*. The process of outlining roles and responsibilities builds predictability, rapport, and skills. It contributes to a sense that this is a collaborative process and that both you and your client have work to do as part of it. Assigned tasks need to be matched with the client's ability and well sequenced in the treatment approach. Clients may either over- or underestimate their skills or abilities; your function is to help them gain insight into their coping and capacity.

For instance, the client may feel that she routinely shuts down when facing an unexpected challenge, but you may have observed her dealing well with the unpredictable behavior of other residents or her own children. You can point out that discrepancy and help her to think of herself in a different light. This may encourage the client to take on more responsibilities or act faster on a plan:

> *As we discussed, I will call the daycare center and make sure that they are still taking our vouchers. I will call them today, and if I'm able to speak with them, I will call you and let you know. If they do take the voucher, we have agreed that you will make an appointment to take a tour of the place and to speak with a worker. Does this reflect what we discussed?*

8. *Summarize the session and set up the follow-up session*. Near the end of the session, restate the session's aim, what was discussed, and what if any steps are to be taken between sessions. This will build predictability and promote safety.

9. *Check-out by saying goodbye*.

Domestic violence. Many homeless women and mothers have domestic or intimate-partner violence as a part of their histories. For some, this violence is acute, and they may have recently transferred from a domestic-violence shelter into the transitional shelter. In some rural areas, because of limited funding or resources, the shelter may provide services for all women in crisis, including those who are actively fleeing a violent relationship. Because of the severity of the crisis, the primary goal of service for victims of violence is stabilization. In these cases, providing treatment or goal-oriented interventions without stabilization is poor practice, and in some cases harmful.

This section, therefore, will address case-management sessions centered on responding to domestic violence and promoting stability, which is the first and most crucial aspect of trauma-informed service delivery. This entails correctly assessing the level of harm the client is facing, understanding the impact of the stressor on her functioning, and determining how to engage in strategic safety planning in response to these factors. Elements of this session can be incorporated into the initial assessment process, especially assessing both the risk and the psychological impact of the violence; it can also be woven into other topic-focused sessions such as on health and human services.

To understand how much danger the woman (and any children) are in, the case manager must appraise the level of harm she is facing. This is called a *risk assessment*. It entails understanding the levels of harm, exposures, or loss experienced in the context of their intimate relationship. Risk assessment does not just ask whether there have been harmful events, but also the kinds of harm experienced and their severity--whether physical, psychological, or emotional. In some cases, there may a high risk of homicide, and fleeing the dangerous partner may place

the client at heightened risk of harm. You can gain a detailed understanding of the risk your client is facing by using the Danger Assessment (DA) scale (see Appendix F).

The DA is a scientifically validated survey that that assesses the likelihood for lethality or near lethality in a situation of interpersonal violence. Understanding the severity of the situation will help you to create a strategic and responsive safety plan. The first portion of the DA asks questions about the frequency and severity of abuse in the past year. It is followed by 20 questions that can be responded to with Yes or No. A total score for the Yes answers helps identify the level of danger. The total scores indicate the following:

(a) 0-7, variable danger,

(b) 9-13, increased danger,

(c) 14-17, severe danger, and

(d) 18 and above, extreme danger.

The DA scale is available free to the public. A client can self-administer the assessment, but it is better practice for you to administer it in the form of a questionnaire. This might be less overwhelming to the client, and you can help pace the questions. Like the Trauma Exposure Questionnaire, the DA asks detailed and personal questions. You must get consent to administer the test and inform the client that she has the right to stop the questions during any part of the assessment. Below is a sample of how you can present the assessment, followed by the DA itself:

> *It is my understanding that you recently experienced/left a situation/relationship that was violent. I am glad you are here and you are safe. It is very brave of you. I am interested in helping keep you safe, and in order to do that I will need to ask you some questions about your situation. It will help me understand how much harm you have experienced and how much risk you continue to face. I am going to be asking questions about your past that are very personal. You do not have to answer any questions you are not*

comfortable with. Your place in the shelter or program will not be taken away if you do not answer the questions.

How would you like to tell me that you do not want to answer a question? Some people say "I am not comfortable answering that," while others simply say "Pass." (Wait to get an answer before moving forward). *You can also take breaks as needed. You can let me know by telling me you need a break, or I will ask you if you need a break if I sense that you might need some space.*

The questions I ask will be about events that were violent, stressful, frightening, or upsetting to you. An example is a question about being hit, slapped, or pushed. The answers to these questions will help me understand how much danger you are facing. Using the answers to these questions, I hope to help you come up with a plan to keep you safe Does this make sense? Do you have any questions for me before we get started? (Pause to get an answer and clarify any questions she may have). *Okay, if you are ready, I would like to get started.*

Figure 4: Danger Assessment

DANGER ASSESSMENT

Jacquelyn C. Campbell, Ph.D., R.N.

Several risk factors have been associated with increased risk of homicides (murders) of women and men in violent relationships. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of abuse and for you to see how many of the risk factors apply to your situation.

Using the calendar, please mark the approximate dates during the past year when you were abused by your partner or ex partner. Write on that date how bad the incident was according to the following scale:

1. Slapping, pushing; no injuries and/or lasting pain
2. Punching, kicking; bruises, cuts, and/or continuing pain
3. "Beating up"; severe contusions, burns, broken bones
4. Threat to use weapon; head injury, internal injury, permanent injury
5. Use of weapon; wounds from weapon

(If **any** of the descriptions for the higher number apply, use the higher number.)

Mark **Yes** or **No** for each of the following. ("He" refers to your husband, partner, ex-husband, ex-partner, or whoever is currently physically hurting you.)

____ 1. Has the physical violence increased in severity or frequency over the past year?
____ 2. Does he own a gun?
____ 3. Have you left him after living together during the past year?
3a. (If have *never* lived with him, check here___)
____ 4. Is he unemployed?
____ 5. Has he ever used a weapon against you or threatened you with a lethal weapon?
(If yes, was the weapon a gun?____)
____ 6. Does he threaten to kill you?
____ 7. Has he avoided being arrested for domestic violence?
____ 8. Do you have a child that is not his?
____ 9. Has he ever forced you to have sex when you did not wish to do so?
____ 10. Does he ever try to choke you?
____ 11. Does he use illegal drugs? By drugs, I mean "uppers" or amphetamines, speed, angel dust, cocaine, "crack", street drugs or mixtures.
____ 12. Is he an alcoholic or problem drinker?
____ 13. Does he control most or all of your daily activities? For instance: does he tell you who you can be friends with, when you can see your family, how much money you can use, or when you can take the car? (If he tries, but you do not let him, check here: ____)
____ 14. Is he violently and constantly jealous of you? (For instance, does he say "If I can't have you, no one can.")
____ 15. Have you ever been beaten by him while you were pregnant? (If you have never been pregnant by him, check here: ____)
____ 16. Have you ever threatened or tried to commit suicide?
____ 17. Has he ever threatened or tried to commit suicide?
____ 18. Does he threaten to harm your children?
____ 19. Do you believe he is capable of killing you?
____ 20. Does he follow or spy on you, leave threatening notes or messages on answering machine, destroy your property, or call you when you don't want him to?

_____ Total "Yes" Answers

As the assessment progresses, you should take note of the client's responses and allow her to process the information. Detailing the abuse using a calendar is intended to raise her awareness and reduce the normalization of the abuse (Campbell, Webster, & Glass, 2009). The overall goal of the assessment is to determine the client's vulnerability to harm and to help eliminate it—or if she is resistant to what that entails, to decrease the violence in her life. You can share the results of the assessment with the client and invite her to engage in evaluating her circumstances and engage in *strategic safety planning*.

Strategic safety planning is an ongoing process rather than a single session centered on safety (Lindhorst, Nuius, & Macy, 2005).. The goal is to achieve nonviolence, not necessarily to leave the relationship. Many factors keep women in abusive relationships, including financial dependence or cultural pressures. Thus, asking the client to leave the relationship without paying attention to her reasons for staying in it is poor practice. It also erroneous to assume that coming to the shelter indicates that she has left the relationship. She may use her stay as a time to rest and determine what steps she will take, including possibly going back to the relationship. Therefore, strategic safety planning should focus on helping her make meaning of the harm she is experiencing, appraising how she is emotionally processing and coping, and making plans to reduce the harm by trying different strategies.

The DA scale will help determine level of risk, but you as case manager will need to understand how the client is internalizing or making meaning of the experience. Her stress response to a crisis like this can entail hyperarousal, avoiding the subject, or experiencing intrusive automatic thoughts. Such symptoms are a normal response to highly dangerous situations, and you can help the client understand her stress response and process its meaning. This can be done by asking the client how she is feeling, functioning, and interacting with others.

She may be able to describe symptoms of intrusion, avoidance, or hyperarousal. You can also use an assessment tool to help gather information on those symptoms. The Impact of Event Scale (IES) is such a tool. It is free to the public and contains 22 questions that ask how distressing the stressful event has been: responses range from *not at all* to *extremely*. You can use the IES to help the client understand her symptoms and strategize on how to help diminish them.

The IES measures reactions to a traumatic event within the past seven days. The three symptoms of intrusion, avoidance, and hyperarousal measure symptoms similar to those of post-traumatic stress disorder (PTSD). Note that the IES is not a psychiatric tool that helps diagnose a person as having PTSD. Rather, it is intended to show the status of symptoms from recent traumatic experience. The scoring for the subscales ranges from 0 to 4, and the closer the subscale score is to 4, the more likely it is that the client is experiencing the related symptom. The IES questionnaire can be self-administered, or administered by you via an interview. You can give the client the choice of how she would like to take the test. However, it is recommended that you as case manager administer the test the first time around. As in administering the DA scale, you explain the purpose of the assessment, get permission from the client to administer the scale, and pace the responses. A sample of the tool is below. (The scale is also available in Appendix F.)

IMPACT OF EVENT SCALE—REVISED

INSTRUCTIONS: Below is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you **DURING THE PAST SEVEN DAYS** with respect to _____, which occurred on _____. How much were you distressed or bothered by these difficulties?

Not at all = 0	A little bit = 1	Moderately = 2	Quite a bit = 3	Extremely = 4

1. Any reminder brought back feelings about it.
2. I had trouble staying asleep.
3. Other things kept making me think about it.
4. I felt irritable and angry.
5. I avoided letting myself get upset when I thought about it or was reminded of it.
6. I thought about it when I didn't mean to.
7. I felt as if it hadn’t happened or wasn’t real.
8. I stayed away from reminders of it.
9. Pictures about it popped into my mind.
10. I was jumpy and easily startled.
11. I tried not to think about it.
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.
13. My feelings about it were kind of numb.
14. I found myself acting or feeling like I was back at that time.
15. I had trouble falling asleep.
16. I had waves of strong feelings about it.
17. I tried to remove it from my memory.
18. I had trouble concentrating.
19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.
20. I had dreams about it.
21. I felt watchful and on-guard.
22. I tried not to talk about it.

The Intrusion subscale is the **MEAN** item response of items 1, 2, 3, 6, 9, 14, 16, 20. Thus, scores can range from 0 through 4.

The Avoidance subscale is the **MEAN** item response of items 5, 7, 8, 11, 12, 13, 17, 22. Thus, scores can range from 0 through 4.

The Hyperarousal subscale is the **MEAN** item response of items 4, 10, 15, 18, 19, 21. Thus, scores can range from 0 through 4.

After you have administered and scored the questionnaire, you should share the information with the client. Ask her for feedback on the process as well what she has learned about her responses to the event. This is another opportunity to appraise the client's situation and help her label and make meaning of her internal conflict. She may have normalized her stress responses and assumed that they were typical. This process will reemphasize how the violence has impacted her functioning. By reflectively listening to her feedback, you build safety and a working alliance. This tool can be used to help monitor progress, administered once a week or as needed.

However, if the client is flooded with intense feelings, safety planning will be overwhelming to her; so instead, you and the client should continue work on stabilizing her. This includes both continuing efforts to main her physical safety and helping her manage the most overwhelming aspects of her crisis. For instance, in the process of fleeing a dangerous situation, she may have left all her belongs behind. She will need help either safely getting access to her possessions or acquiring resources with which to start over. As such efforts proceed, by assessing her emotional state, you and the client can determine what steps must be taken to prepare for strategic safety planning.

Although her stress response is normal and should not be pathologized, the client should not have to remain in dangerous circumstances that sustain the stress. As noted, the goal of strategic safety planning is to achieve nonviolence, not necessarily to end the relationship in which the violence occurred. The DA will establish the level of harm, and you can take the results and make further inquiries about other, secondary forms of harm she is facing; these should include possible emotional and cultural harm.

Depending on the client, harm experienced in one of both of those domains, rather than physical harm, may be considered the most salient or meaningful issue to be addressed in creating a safety plan. For instance, in some cultures, maintaining the family structure is seen as the most important cultural norm; confronting an abuser or leaving an abusive relationship may result in withdrawal of social supports. This may cause the client to be more isolated or exposed to more harm. Accordingly, the client must develop additional supports in order to sustain a safe existence, and case management sessions should focus collaboratively on how to do that. Sessions dedicated to safety planning would follow the same format as other case management sessions:

1. Check-in
2. Review the objective of the session
3. Review past attempts to meet the need
4. Review resources, strengths, and cultural considerations
5. Review external and internal barriers
6. Determine the steps that need to be taken
7. Determine roles and responsibilities
8. Summarize the session and set up follow-up session
9. Check-out

The initial sessions should focus on crisis management and stabilization, which will entail assessing risk and evaluating the emotional impact, as outlined above. The results of that process will set the agenda and pace for meeting other goals should the client remain in the shelter. Task-oriented sessions related to safety, such as filing for legal protection from abuse or accessing public assistance, can follow sessions outlined in the Health and Human Services

section of this curriculum. This section details how to engage the client in sequenced format using trauma-informed principles.

Emotional regulation. Being homeless is a difficult experience, and it is natural for homeless individuals to experience distressing emotions. Thus, a case manager must be equipped to help the client navigate the distressing emotions. Skills that are helpful in managing emotional distress are (a) identifying and labeling emotions, (b) creating a self-care plan, and (c) having a technique to reduce overwhelming feelings (Linehan, 1993). Tolerating and managing emotions will help the client better meet her tasks. This section will detail how to teach the skills listed.

Identifying and labeling emotions. The process of identifying and labeling emotions entails being able to classify the emotion as well as specify its frequency and intensity. In extremely stressful situations, such as being homeless, the feelings experienced can range from intense sadness, fear, and anger to numbness. The client may not be able articulate her emotion or know what to do with it. You can supply a list of emotions and ask the woman to identify which one expresses her state. If she cannot articulate the emotion, physical sensations in the body can be used as cues to inform emotional states. For instance, a case manager can ask the client: Does your stomach feel upset or is there tightness in your body? Labeling and making meaning of an emotion is a critical aspect of providing trauma-informed services.

Creating a self-care plan. Self-care strategies address what to do when a person feels bad (Najavits, 2002). You should ask the client questions about how she is addressing her daily needs, including nutrition, sleep, and exercise. Often, survival behaviors include neglecting essential things that are needed for overall health: adequate sleep or nutritious food can seem like luxury items. Once a woman enters the shelter, she can attend to these needs with your help as her case

manager. Furthermore, you can ask a series of questions to help facilitate a self-care plan. They are as follows:

- *When you feel bad, what can you do to take care of yourself?*
- *Who can you count on to comfort you?*
- *What can you do when there is not someone there to help you feel better?*

These questions will help guide the conversation so that you and your client can strategize on creating a self-care plan.

A technique to reduce overwhelming feelings. Grounding is a useful technique for dealing with overwhelming feelings. Grounding, or centering, can help clients in hyperaroused states by distracting them from the feelings and connecting them to the external world (Courtois & Ford, 2013). Clients can engage in *mental*, *physical*, and *soothing* grounding.

Mental grounding means focusing the mind by becoming aware of the immediate environment or switching the mind away from the overwhelming emotions by giving it something else to do. One way is describing the environment in detail (size, color, and placement) by observing objects in the room and describing them. Another is to engage in distracting exercises such as thinking of categories of objects, or counting or repeating the alphabet slowly or in a pattern. A third is to make a safety statement: the client states her name and her location and reminds herself that she is safe: "My name is Maria. I am at shelter, and I am safe."

Physical grounding involves the use of the senses, such hearing or touch, to focus on the here and now. At a minimum, it means noticing where one's physical body is, focusing on anchoring the self to the environment. This can include taking note of where one's arms and legs are and planting them more firmly. Engaging in appropriate physical activity such as stretching, clenching and releasing muscles, or walking can also connect the senses to the environment. As

with such mindful exercise, physical grounding can also be accomplished via the breath by paying attention to inhalation or exhalation. Lastly, one can carry a grounding object, similar to a transitional object, which can be touched when one is triggered. This object can be a small rock, stress ball, or something with a comforting memory. It can work as a comforting connection to the environment.

Soothing grounding is focusing on positive and helpful thoughts about oneself and one's life. This can start with asserting confidence or the ability to cope: "I am going to be okay" or I can do this." Soothing grounding is an active process of self-care. It may further involve thinking and listing favorite things, people, and objects and mentally describing details of each category. Soothing grounding can also be accomplished by thinking about activities that are pleasurable or things that one is looking forward to accomplishing in the next week. An example of this can be thoughts of meeting a friend or going for a walk.

Grounding techniques are different from relaxation techniques; grounding aims to actively connect one with the environment rather than mentally escaping it (Najavits, 2002). Grounding can be taught as a simple but powerful coping strategy. It is best to conduct a guided grounding in a case-management session to introduce and practice the technique. You can have the client think of a distressing situation as an example that prompts intense feelings. The client can rate the intensity of the feeling on a scale of 1 to 10. You can then ask the client to temporarily put the emotions aside and guide her through a mental, physical, and soothing grounding process.

When this process is complete, ask the client to think of the previously mentioned emotion and rate it again. If all goes well, the technique has helped bring the emotion into a lower, or preferably neutral, state. Identifying which techniques the client found helpful can aid

the case manager in tailoring the grounding. These techniques work best when they are repeatedly practiced and can eventually become a natural coping strategy for the client. Scripts for guided grounding can be accessed on the Internet or from one of the recommended skills-training manuals in the resource section in Appendix J of this curriculum.

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Appendix A: Life Events Checklist

LIFE EVENTS CHECKLIST

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it *happened to you* personally, (b) you *witnessed it* happen to someone else, (c) you *learned about it* happening to someone close to you, (d) you're *not sure* if it fits, or (e) it *doesn't apply* to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Not Sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden, violent death (for example, homicide, suicide)					
15. Sudden, unexpected death of someone close to you					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience					

Appendix B: Secondary Traumatic Stress Scale

SECONDARY TRAUMATIC STRESS SCALE

The following is a list of statements made by persons who have been impacted by their work with traumatized clients. Read each statement then indicate how frequently the statement was true for you in the past **seven (7) days** by circling the corresponding number next to the statement.

NOTE: *"Client" is used to indicate persons with whom you have been engaged in a helping relationship. You may substitute another noun that better represents your work such as consumer, patient, recipient, etc.*

	Never	Rarely	Occasionally	Often	Very Often
1. I felt emotionally numb.....	1	2	3	4	5
2. My heart started pounding when I thought about my work with clients.....	1	2	3	4	5
3. It seemed as if I was reliving the trauma(s) experienced by my client(s).....	1	2	3	4	5
4. I had trouble sleeping.....	1	2	3	4	5
5. I felt discouraged about the future.....	1	2	3	4	5
6. Reminders of my work with clients upset me.....	1	2	3	4	5
7. I had little interest in being around others.....	1	2	3	4	5
8. I felt jumpy.....	1	2	3	4	5
9. I was less active than usual.....	1	2	3	4	5
10. I thought about my work with clients when I didn't intend to.....	1	2	3	4	5
11. I had trouble concentrating.....	1	2	3	4	5
12. I avoided people, places, or things that reminded me of my work with clients.....	1	2	3	4	5
13. I had disturbing dreams about my work with clients.....	1	2	3	4	5
14. I wanted to avoid working with some clients.....	1	2	3	4	5
15. I was easily annoyed.....	1	2	3	4	5
16. I expected something bad to happen.....	1	2	3	4	5
17. I noticed gaps in my memory about client sessions.....	1	2	3	4	5

Intrusion Subscale (add items 2, 3, 6, 10, 13)	Intrusion Score _____
Avoidance Subscale (add items 1, 5, 7, 9, 12, 14, 17)	Avoidance Score _____
Arousal Subscale (add items 4, 8, 11, 15, 16)	Arousal Score _____
TOTAL (add Intrusion, Arousal, and Avoidance Scores)	Total Score _____

Appendix C: Life Stressor Checklist–Revised

READ THIS FIRST: Now we are going to ask you some questions about events in your life that are frightening, upsetting, or stressful to most people. Please think back over your **whole life** when you answer these questions. Some of these questions may be about upsetting events you don't usually talk about. Your answers are important, but **you do not have to answer any questions that you do not want to**. Thank you.

1. Have you ever been in a serious disaster (for example, an earthquake, hurricane, large fire, explosion)? ☐ Yes ☐ No

a. How old were you when this happened? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not at all some extremely

2. Have you ever seen a serious accident (for example, a bad car wreck or an on-the-job accident)? ☐ Yes ☐ No

a. How old were you when this happened? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not at all some extremely

3. Have you ever had a very serious accident or accident-related injury (for example, a bad car wreck or an on-the-job accident)? ☐ Yes ☐ No

a. How old were you when this happened? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not at all some extremely

4. Was a close family member ever sent to jail? ☐ Yes ☐ No

a. How old were you when this happened? ☐☐ b. When it ended? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not at all some extremely

5. Have you ever been sent to jail? ☐ Yes ☐ No

a. How old were you when this happened? ☐☐ b. When it ended? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 not at all ☐ 2 ☐ 3 some ☐ 4 ☐ 5 extremely

6. Were you ever put in foster care or put up for adoption? ☐ Yes ☐ No

a. How old were you when this happened? ☐☐ b. When it ended? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 not at all ☐ 2 ☐ 3 some ☐ 4 ☐ 5 extremely

7. Did your parents ever separate or divorce while you were living with them? ☐ Yes ☐ No

a. How old were you when this happened? ☐☐ b. When it ended? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 not at all ☐ 2 ☐ 3 some ☐ 4 ☐ 5 extremely

8. Have you ever been separated or divorced? ☐ Yes ☐ No

a. How old were you when this happened? ☐☐ b. When it ended? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 not at all ☐ 2 ☐ 3 some ☐ 4 ☐ 5 extremely

9. Have you ever had serious money problems (for example, not enough money for food or place to live)? ☐ Yes ☐ No

a. How old were you when this happened? ☐☐ b. When it ended? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 not at all ☐ 2 ☐ 3 some ☐ 4 ☐ 5 extremely

10. Have you ever had a very serious physical or mental illness (for example, cancer, heart attack, serious operation, felt like killing yourself, hospitalized because of nerve problems)? ☐ Yes ☐ No

a. How old were you when this happened? ☐☐ b. When it ended? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 not at all ☐ 2 ☐ 3 some ☐ 4 ☐ 5 extremely

11. Have you ever been emotionally abused or neglected (for example, being frequently shamed, embarrassed, ignored, or repeatedly told that you were "no good")? ☐ Yes ☐ No

a. How old were you when this happened? ☐☐ b. When it ended? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 not at all ☐ 2 ☐ 3 some ☐ 4 ☐ 5 extremely

12. Have you ever been physically neglected (for example, not fed, not properly clothed, or left to take care of yourself when you were too young or ill)? ☐ Yes ☐ No

a. How old were you when this happened? ☐☐ b. When it ended? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 not at all ☐ 2 ☐ 3 some ☐ 4 ☐ 5 extremely

13. WOMEN ONLY: Have you ever had an abortion or miscarriage (lost your baby)? ☐ Yes ☐ No

a. How old were you when this happened? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 not at all ☐ 2 ☐ 3 some ☐ 4 ☐ 5 extremely

14. Have you ever been separated from your child against your will (for example, the loss of custody or visitation or kidnapping? ☐ Yes ☐ No

a. How old were you when this happened? ☐☐ b. When it ended? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 not at all ☐ 2 ☐ 3 some ☐ 4 ☐ 5 extremely

15. Has a baby or child of yours ever had a severe physical or mental handicap (for example, mentally retarded, birth defects, can't hear, see, walk)? ☐ Yes ☐ No

a. How old were you when this happened? ☐☐ b. When it ended? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 not at all ☐ 2 ☐ 3 some ☐ 4 ☐ 5 extremely

16. Have you ever been responsible for taking care of someone close to you (not your child) who had a severe physical or mental handicap (for example, cancer, stroke, AIDS, nerve problems, can't hear, see, walk) ☐ Yes ☐ No

a. How old were you when this happened? ☐☐ b. When it ended? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 not at all ☐ 2 ☐ 3 some ☐ 4 ☐ 5 extremely

17. Has someone close to you died suddenly or unexpectedly (for example, sudden heart attack, murder or suicide)? ☐ Yes ☐ No

a. How old were you when this happened? ☐☐ b. When it ended? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 not at all ☐ 2 ☐ 3 some ☐ 4 ☐ 5 extremely

18. Has someone close to you died (do NOT include those who died suddenly or unexpectedly)? ☐ Yes ☐ No

a. How old were you when this happened? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 not at all ☐ 2 ☐ 3 some ☐ 4 ☐ 5 extremely

19. When you were young (before age 16). did you ever see violence between family members (for example, hitting, kicking, slapping, punching)? ☐ Yes ☐ No

a. How old were you when this happened? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 not at all ☐ 2 ☐ 3 some ☐ 4 ☐ 5 extremely

20. Have you ever seen a robbery, mugging, or attack taking place? ☐ Yes ☐ No

a. How old were you when this happened? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not at all some extremely

21. Have you ever been robbed, mugged, or physically attacked (not sexually) by someone you did not know? ☐ Yes ☐ No

a. How old were you when this happened? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not at all some extremely

22. *Before age 16*, were you ever abused or physically attacked (not sexually) by someone you knew (for example, a parent, boyfriend, or husband, hit, slapped, choked, burned, or beat you up? ☐ Yes ☐ No

a. How old were you when this happened? ☐☐ b. When it ended? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not at all some extremely

23. *After age 16*, were you ever abused or physically attacked (not sexually) by someone you knew (for example, a parent, boyfriend, or husband hit, slapped, choked, burned, or beat you up) ☐ Yes ☐ No

a. How old were you when this happened? ☐☐ b. When it ended? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not at all some extremely

24. Have you ever been bothered or harassed by sexual remarks, jokes, or demands for sexual favors by someone at work or school (for example, a coworker, a boss, a customer, another student, a teacher)? ☐ Yes ☐ No

a. How old were you when this happened? ☐☐ b. When it ended? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not at all some extremely

25. *Before age 16*, were you ever touched or made to touch someone else in a sexual way because he/she forced you in some way or threatened to harm you if you didn't? ☐ Yes ☐ No

a. How old were you when this happened? ☐☐ b. When it ended? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not at all some extremely

26. *After age 16*, were you ever touched or made to touch someone else in a sexual way because he/she forced you in some way or threatened to harm you if you didn't? ☐ Yes ☐ No

a. How old were you when this happened? ☐☐ b. When it ended? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not at all some extremely

27. *Before age 16*, did you ever have sex (oral, anal, genital) when you didn't want to because someone forced you in some way or threatened to hurt you if you didn't? ☐ Yes ☐ No

a. How old were you when this happened? ☐☐ b. When it ended? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not at all some extremely

28. After age 16, did you ever have sex (oral, anal, genital) when you didn't want to because someone forced you in some way or threatened to harm you if you didn't? ☐ Yes ☐ No

a. How old were you when this happened? ☐☐ b. When it ended? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not at all some extremely

29. Are there any events we did not include that you would like to mention? ☐ Yes ☐ No

What was the event? _____

a. How old were you when this happened? ☐☐ b. When it ended? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not at all some extremely

30. Have any of the events mentioned above ever happened to someone close to you so that even though you didn't see it yourself, you were seriously upset by it? ☐ Yes ☐ No

What was the event? _____

a. How old were you when this happened? ☐☐ b. When it ended? ☐☐

c. At the time of the event did you believe that ***you or someone else*** could be ***killed*** or seriously ***harmed?*** ☐ Yes ☐ No

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ☐ Yes ☐ No

e. How much is this affected your life in the past year? ☐ 1 **not at all** ☐ 2 ☐ 3 **some** ☐ 4 ☐ 5 **extremely**

Appendix D: University of Rhode Island Change Assessment Scale (URICA)

EACH STATEMENT BELOW DESCRIBES HOW A PERSON MIGHT FEEL WHEN STARTING THERAPY OR APPROACHING PROBLEMS IN THEIR LIVES. PLEASE INDICATE THE EXTENT TO WHICH YOU TEND TO AGREE OR DISAGREE WITH EACH STATEMENT. IN EACH CASE, MAKE YOUR CHOICE IN TERMS OF HOW YOU FEEL RIGHT NOW, NOT WHAT YOU HAVE FELT IN THE PAST OR WOULD LIKE TO FEEL. FOR ALL STATEMENTS THAT REFER TO YOUR PROBLEM ANSWER IN TERMS OF PROBLEMS RELATED TO THE GOAL YOU ARE FOCUSING ON.

THERE ARE FIVE POSSIBLE RESPONSES TO EACH OF THE ITEMS IN THE QUESTIONNAIRE:
1=Strongly Disagree
2=Disagree
3=Undecided
4=Agree
5=Strongly Agree
CIRCLE THE NUMBER THAT BEST DESCRIBES HOW MUCH YOU AGREE OR DISAGREE WITH EACH STATEMENT.

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1. As far as I'm concerned, I don't have any problems that need changing.	1	2	3	4	5
2. I think I might be ready for some self-improvement.	1	2	3	4	5
3. I am doing something about the problems that had been bothering me.	1	2	3	4	5
4. It might be worthwhile to work on my problem.	1	2	3	4	5
5. I'm not the problem one. It doesn't make much sense for me to be here.	1	2	3	4	5
6. It worries me that I might slip back on a problem I have already changed, so I am here to seek help.	1	2	3	4	5
7. I am finally doing some work on my problems.	1	2	3	4	5
8. I've been thinking that I might want to change something about myself.	1	2	3	4	5

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
9. I have been successful in working on my problem but I'm not sure I can keep up the effort on my own.	1	2	3	4	5
10. At times my problem is difficult, but I'm working on it.	1	2	3	4	5
11. Trying to change is pretty much a waste of time for me because the problem doesn't have to do with me.	1	2	3	4	5
12. I'm hoping this place will help me to better understand myself.	1	2	3	4	5
13. I guess I have faults, but there's nothing that I really need to change.	1	2	3	4	5
14. I am really working hard to change.	1	2	3	4	5
15. I have a problem and I really think I should work on it.	1	2	3	4	5
16. I'm not following though with what I had already changed as well as I had hoped, and I'm here to prevent a relapse of the problem.	1	2	3	4	5
17. Even though I'm not always successful in changing, I am at least working on my problem.	1	2	3	4	5
18. I thought once I had resolved the problem I would be free of it, but sometimes I still find myself struggling with it.	1	2	3	4	5
19. I wish I had more ideas on how to solve my problem.	1	2	3	4	5
20. I have started working on my problems but I would like help.	1	2	3	4	5
21. Maybe this place will be able to help me.	1	2	3	4	5

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
22. I may need a boost right now to help me maintain the changes I've already made.	1	2	3	4	5
23. I may be part of the problem, but I don't really think I am.	1	2	3	4	5
24. I hope that someone here will have some good advice for me.	1	2	3	4	5
25. Anyone can talk about changing; I'm actually doing something about it.	1	2	3	4	5
26. All this talk about psychology is boring. Why can't people just forget about their problems?	1	2	3	4	5
27. I'm here to prevent myself from having a relapse of my problem.	1	2	3	4	5
28. It is frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved.	1	2	3	4	5
29. I have worries but so does the next person. Why spend time thinking about them?	1	2	3	4	5
30. I am actively working on my problem.	1	2	3	4	5
31. I would rather cope with my faults than try to change them.	1	2	3	4	5
32. After all I had done to try and change my problem, every now and then it comes back to haunt me.	1	2	3	4	5

Scoring for URICA

Calculating The Readiness Score

Calculating the Readiness Score is done by calculating the means for pre contemplation responses, contemplation responses, action responses and the struggling to maintain responses. Once means are found for each of the stage subscales, the mean from the pre contemplation is subtracted from the summation of the other three stages. Below you will find grids showing which questions are used to calculate each of the subscale totals, the number to divide by to obtain the mean and the formula below each grid to calculate the readiness score. Remember, if you alter the order of the questions from the order already used in our versions of the URICA, you must adjust the grid to account for changes in numbering to be certain the questions are correctly linked to the stages.

Cut-Off Scores

Cut-off scores can be created for the readiness score but it is important to consider your population and how conservative you want to be. Cut-off scores are essentially arbitrary and you should be thinking about the stages as least ready, middle and most ready.

For the general population, the following cut-off scores may be appropriate:
8 or lower classified as Precontemplators
8-11 classified as Contemplators
11-14 classified as Preparators into Action Takers
For intensive service populations, it may be more appropriate to use only score in the range of 12-14 to classify those in preparation and action.

URICA 32-Item Version

	Precontemplation	*Contemplation*	*Action*	*Maintenance*
Question Numbers	1	2	3	6
	5	4 (omit)*	7	9 (omit)*
	11	8	10	16
	13	12	14	18
	23	15	17	22
	26	19	20 (omit)*	27
	29	21	25	28
	31 (omit)*	24	30	32
Total:				
Divide by:	7	7	7	7
Mean:				

*For the questions that say "Omit" do not include them in your summation of scores for each stage subscale.
To obtain a Readiness to Change score, first sum items from each subscale and divide by 7 to get the mean for each subscale. Then sum the means from the Contemplation, Action, and Maintenance subscales and subtract the Precontemplation mean (C + A + M – PC = Readiness).

Appendix E: Simple Screening Instrument for Substance Abuse

Simple Screening Instrument for Substance Abuse Interview Form

Note: **Boldfaced** questions constitute a short version of the screening instrument that can be administered in situations that are not conducive to administering the entire test. Such situations may occur because of time limitations or other conditions.

Introductory statement:

"I'm going to ask you a few questions about your use of alcohol and other drugs during the past 6 months. Your answers will be kept private. Based on your answers to these questions, we may advise you to get a more complete assessment. This would be voluntary—it would be your choice whether to have an additional assessment or not."

During the past 6 months…

1. **Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opioids, uppers, downers, hallucinogens, or inhalants.)** (yes/no)
2. **Have you felt that you use too much alcohol or other drugs?** (yes/no)
3. **Have you tried to cut down or quit drinking or using drugs?** (yes/no)
4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.) (yes/no)
5. Have you had any of the following?
   - Blackouts or other periods of memory loss
   - Injury to your head after drinking or using drugs
   - Convulsions, or delirium tremens ("DTs")
   - Hepatitis or other liver problems
   - Feeling sick, shaky, or depressed when you stopped drinking or using drugs
   - Feeling "coke bugs," or a crawling feeling under the skin, after you stopped using drugs
   - Injury after drinking or using drugs
   - Using needles to shoot drugs
6. Has drinking or other drug use caused problems between you and your family or friends? (yes/no)
7. Has your drinking or other drug use caused problems at school or at work? (yes/no)
8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.) (yes/no)
9. Have you lost your temper or gotten into arguments or fights while drinking or using drugs? (yes/no)
10. Are you needing to drink or use drugs more and more to get the effect you want? (yes/no)
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs? (yes/no)
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone? (yes/no)

Simple Screening Instrument for Substance Abuse Interview Form

13. Do you feel bad or guilty about your drinking or drug use? (yes/no)

    Now I have some questions that are not limited to the past 6 months.

14. Have you ever had a drinking or other drug problem? (yes/no)
15. Have any of your family members ever had a drinking or drug problem? (yes/no)
16. **Do you feel that you have a drinking or drug problem now?** (yes/no)

- Thanks for answering these questions.
- Do you have any questions for me?
- Is there something I can do to help you?

Notes: _____

_____

_____

_____

_____

_____

Observation Checklist

The following signs and symptoms may indicate a substance abuse problem in the individual being screened:

- Needle track marks
- Skin abscesses, cigarette burns, or nicotine stains
- Tremors (shaking and twitching of hands and eyelids)
- Unclear speech: slurred, incoherent, or too rapid
- Unsteady gait: staggering, off balance
- Dilated (enlarged) or constricted (pinpoint) pupils
- Scratching
- Swollen hands or feet
- Smell of alcohol or marijuana on breath
- Drug paraphernalia such as pipes, paper, needles, or roach clips
- "Nodding out" (dozing or falling asleep)
- Agitation
- Inability to focus
- Burns on the inside of the lips (from freebasing cocaine)

Scoring for the Simple Screening Instrument for Substance Abuse

Name/ID No.: _____ Date: _____

Place/Location: _____

Items 1 and 15 are not scored. The following items are scored as 1 (yes) or 0 (no):

___ 2	___ 7	___ 12
___ 3	___ 8	___ 13
___ 4	___ 9	___ 14
___ 5 (any items listed)	___ 10	___ 16
___ 6	___ 11	

Total score: ____ Score range: 0-14

Preliminary interpretation of responses:

Score	Degree of Risk for Substance Abuse
0-1	None to low
2-3	Minimal
>4	Moderate to high: possible need for further assessment

Appendix F: Danger Assessment

DANGER ASSESSMENT

Jacquelyn C. Campbell, Ph.D., R.N.

Several risk factors have been associated with increased risk of homicides (murders) of women and men in violent relationships. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of abuse and for you to see how many of the risk factors apply to your situation.

Using the calendar, please mark the approximate dates during the past year when you were abused by your partner or ex partner. Write on that date how bad the incident was according to the following scale:

1. Slapping, pushing; no injuries and/or lasting pain
2. Punching, kicking; bruises, cuts, and/or continuing pain
3. "Beating up"; severe contusions, burns, broken bones
4. Threat to use weapon; head injury, internal injury, permanent injury
5. Use of weapon; wounds from weapon

(If **any** of the descriptions for the higher number apply, use the higher number.)

Mark **Yes** or **No** for each of the following. ("He" refers to your husband, partner, ex-husband, ex-partner, or whoever is currently physically hurting you.)

____ 1. Has the physical violence increased in severity or frequency over the past year?
____ 2. Does he own a gun?
____ 3. Have you left him after living together during the past year?
3a. (If have *never* lived with him, check here___)
____ 4. Is he unemployed?
____ 5. Has he ever used a weapon against you or threatened you with a lethal weapon?
(If yes, was the weapon a gun?____)
____ 6. Does he threaten to kill you?
____ 7. Has he avoided being arrested for domestic violence?
____ 8. Do you have a child that is not his?
____ 9. Has he ever forced you to have sex when you did not wish to do so?
____ 10. Does he ever try to choke you?
____ 11. Does he use illegal drugs? By drugs, I mean "uppers" or amphetamines, speed, angel dust, cocaine, "crack", street drugs or mixtures.
____ 12. Is he an alcoholic or problem drinker?
____ 13. Does he control most or all of your daily activities? For instance: does he tell you who you can be friends with, when you can see your family, how much money you can use, or when you can take the car? (If he tries, but you do not let him, check here: ____)
____ 14. Is he violently and constantly jealous of you? (For instance, does he say "If I can't have you, no one can.")
____ 15. Have you ever been beaten by him while you were pregnant? (If you have never been pregnant by him, check here: ____)
____ 16. Have you ever threatened or tried to commit suicide?
____ 17. Has he ever threatened or tried to commit suicide?
____ 18. Does he threaten to harm your children?
____ 19. Do you believe he is capable of killing you?
____ 20. Does he follow or spy on you, leave threatening notes or messages on answering machine, destroy your property, or call you when you don't want him to?

_____ Total "Yes" Answers

Appendix G: Impact of Event Scale

INSTRUCTIONS: Below is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you **DURING THE PAST SEVEN DAYS** with respect to _____, which occurred on _____. How much were you distressed or bothered by these difficulties?

Not at all = 0	A little bit = 1	Moderately = 2	Quite a bit = 3	Extremely = 4

1. Any reminder brought back feelings about it.
2. I had trouble staying asleep.
3. Other things kept making me think about it.
4. I felt irritable and angry.
5. I avoided letting myself get upset when I thought about it or was reminded of it.
6. I thought about it when I didn't mean to.
7. I felt as if it hadn't happened or wasn't real.
8. I stayed away from reminders of it.
9. Pictures about it popped into my mind.
10. I was jumpy and easily startled.
11. I tried not to think about it.
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.
13. My feelings about it were kind of numb.
14. I found myself acting or feeling like I was back at that time.
15. I had trouble falling asleep.
16. I had waves of strong feelings about it.
17. I tried to remove it from my memory.
18. I had trouble concentrating.
19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.
20. I had dreams about it.
21. I felt watchful and on-guard.
22. I tried not to talk about it.

The Intrusion subscale is the **MEAN** item response of items 1, 2, 3, 6, 9, 14, 16, 20. Thus, scores can range from 0 through 4.

The Avoidance subscale is the **MEAN** item response of items 5, 7, 8, 11, 12, 13, 17, 22. Thus, scores can range from 0 through 4.

The Hyperarousal subscale is the **MEAN** item response of items 4, 10, 15, 18, 19, 21. Thus, scores can range from 0 through 4.

Citations: Weiss, D.S. & Marmar, C.R. (1997). The Impact of Event Scale-Revised. In J.P. Wilson, & T. M. Keane (Eds.), *Assessing Psychological Trauma and PTSD: A Practitioner's Handbook*. (pp. 399-411). New York: Guilford. Weiss, D. S. (2004). The Impact of Event Scale-Revised. In J. P. Wilson, & T. M. Keane (Eds.), *Assessing psychological trauma and PTSD: A practitioner's handbook* (2nd ed., pp. 168-189). New York: Guilford Press.

Appendix H: Drug Abuse Screening Test

The Drug Abuse Screening Test (DAST) was developed in 1982 and is still an excellent screening tool. It is a 28-item self-repo scale that consists of items that parallel those of the Michigan Alcoholism Screening Test (MAST). The DAST has "exhibited v psychometric properties" and has been found to be "a sensitive screening instrument for the abuse of drugs other than alcoho

The Drug Abuse Screening Test (DAST)

Directions: The following questions concern information about your involvement with drugs. Drug abuse refers to (1) t use of prescribed or "over-the-counter" drugs in excess of the directions, and (2) any non-medical use of drugs. Conside the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and chec the appropriate space. Please be sure to answer every question.

		YES	NO
1.	Have you used drugs other than those required for medical reasons?	___	___
2.	Have you abused prescription drugs?	___	___
3.	Do you abuse more than one drug at a time?	___	___
4.	Can you get through the week without using drugs (other than those required for medical reasons)?	___	___
5.	Are you always able to stop using drugs when you want to?	___	___
6.	Do you abuse drugs on a continuous basis?	___	___
7.	Do you try to limit your drug use to certain situations?	___	___
8.	Have you had "blackouts" or "flashbacks" as a result of drug use?	___	___
9.	Do you ever feel bad about your drug abuse?	___	___
10.	Does your spouse (or parents) ever complain about your involvement with drugs?	___	___
11.	Do your friends or relatives know or suspect you abuse drugs?	___	___
12.	Has drug abuse ever created problems between you and your spouse?	___	___
13.	Has any family member ever sought help for problems related to your drug use?	___	___
14.	Have you ever lost friends because of your use of drugs?	___	___
15.	Have you ever neglected your family or missed work because of your use of drugs?	___	___
16.	Have you ever been in trouble at work because of drug abuse?	___	___
17.	Have you ever lost a job because of drug abuse?	___	___
18.	Have you gotten into fights when under the influence of drugs?	___	___
19.	Have you ever been arrested because of unusual behavior while under the influence of drugs?	___	___
20.	Have you ever been arrested for driving while under the influence of drugs?	___	___
21.	Have you engaged in illegal activities in order to obtain drug?	___	___
22.	Have you ever been arrested for possession of illegal drugs?	___	___
23.	Have you ever experienced withdrawal symptoms as a result of heavy drug intake?	___	___
24.	Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	___	___
25.	Have you ever gone to anyone for help for a drug problem?	___	___
26.	Have you ever been in a hospital for medical problems related to your drug use?	___	___
27.	Have you ever been involved in a treatment program specifically related to drug use?	___	___
28.	Have you been treated as an outpatient for problems related to drug abuse?	___	___

Scoring and interpretation: A score of "1" is given for each YES response, except for items 4,5, and 7, for which a NO response is given a score of "1." Based on data from a heterogeneous psychiatric patient population, cutoff scores of 6 through 11 are considered to be optimal for screening for substance use disorders. Using a cutoff score of 6 has been found to provide excellent sensitivity for identifying patients with substance use disorders as well as

satisfactory specificity (i.e., identification of patients who do not have substance use disorders). Using a cutoff score of <11 somewhat reduces the sensitivity for identifying patients with substance use disorders, but more accurately identifies the patients who do not have substance use disorders. Over 12 is definitely a substance abuse problem.

Appendix I: Managed Health Care Organizational Readiness Checklist (Excerpts)

No, None, Never	Very Limited, Not Often	Partially, Frequently	Mostly, Regularly	Yes, Fully, Always
1	2	3	4	5

Service Comprehensiveness

For adults, do you deliver:	*Please circle the answer...*
1. Centralized screening, assessment, intake, and crisis intervention services?	1 2 3 4 5
2. Comprehensive outpatient services?	1 2 3 4 5
3. Intensive outpatient services, or do you have strong network relationships with providers of such services?	1 2 3 4 5
4. Partial hospitalization/day treatment services, or do you have strong network relationships with providers of such services?	1 2 3 4 5
5. Short-term residential treatment, or do you have strong network relationships with providers of such services?	1 2 3 4 5
6. Inpatient treatment, or do you have strong network relationships with providers of such services?	1 2 3 4 5
For children and adolescents, do you deliver:	
7. Centralized screening, assessment, intake, and crisis intervention services?	1 2 3 4 5
8. Outpatient services?	1 2 3 4 5
9. Intensive outpatient services, or do you have strong network relationships with providers of such services?	1 2 3 4 5
10. Partial hospitalization/day treatment services, or do you have strong network relationships with providers of such services?	1 2 3 4 5
11. Short-term residential treatment, or do you have strong network relationships with providers of such services?	1 2 3 4 5
12. Inpatient treatment, or do you have strong network relationships with providers of such services?	1 2 3 4 5

No, None, Never	Very Limited, Not Often	Partially, Frequently	Mostly, Regularly	Yes, Fully, Always
1	2	3	4	5

Service Characteristics

Please circle the answer...

13.	Do you have skilled clinical staff assigned to all aspects of the screening and assessment process, including initial telephone contacts?	1	2	3	4	5
14.	Do your services ensure rapid access (1-2 days) to assessment services and initial placement?	1	2	3	4	5
15.	Do your services have a brief intervention focus, e.g., six to eight sessions for outpatient care, for most patients?	1	2	3	4	5
16.	Do you have internal case management services for focusing on repeating patients and others who have high utilization patterns?	1	2	3	4	5
17.	Do you have ensured linkages with primary healthcare providers for needed healthcare?	1	2	3	4	5
18.	Do you adapt standard services to meet the needs of special populations, such as mentally ill substance abusers, injecting drug users, and pregnant addicts?	1	2	3	4	5
19.	Are service needs constantly reevaluated, and service plans modified, based on patient progress?	1	2	3	4	5
20.	Are admission, treatment, and discharge criteria in place and used consistently by staff?	1	2	3	4	5
21.	Do your admission, treatment, and discharge criteria take into consideration the practice standards of managed care firms with which you have (or hope to have) contracts?	1	2	3	4	5
22.	Do your services ensure rapid linkage to succeeding levels of care?	1	2	3	4	5
23.	Do your services emphasize family involvement and use of natural support systems, including self-help groups?	1	2	3	4	5
24.	Do your services focus on patient outcomes and satisfaction?	1	2	3	4	5

Appendix J: Resources

Helpful Toolkits

A long journey home: A guide for creating trauma-informed services for mothers and children experiencing homelessness. Rockville, MD: Center for Mental Health Services, Substance Abuse, and Mental Health Service Administration; Daniels Fund; National Child Traumatic Stress Network; and W.K. Kellogg Foundation.
Available at: http://homeless.samhsa.gov

Prescott, L., Soares, P. Konnath, K., & Bassuk, E. (2008). *Trauma-Informed Organizational Toolkit for Homeless Services*
Available at: http://homeless.samhsa.gov and http://www.familyhomelessness.org

Guarino, K. Soares, P., Konnath, K. Clervil, R., & Bassuk E. (2009). *Trauma-Informed organizational toolkit.* Rockville, MD: Center for Mental Health Services, Substance Abuse, and Mental Health Services; Daniels Fund, National Child Traumatic Stress Network; and W.K. Kellogg Foundation
Available at: www.familyhomelessness.org/media/90.pd

Gabowitz, D. & Konnath, K. (2008). *Developing trauma-informed services for families experiencing homelessness: An interactive training video and guide.*
Available at the Trauma Center at the Justice Resource Institute
(http://www.traumacenter.org/index.php)
The materials can also be ordered through by mail:

Shannon Smith, Program Assistant
The Trauma Center at JRI
1269 Beacon Street, 1st Floor
Brookline, MA 02446

Helpful Websites

Community Connections
www.communityconnectionsdc.org

Homeless Resource Center
http://homeless.samhsa.gov

The International Society for Traumatic Stress Studies (ISTSS)
www.istss.org

National Center for Trauma-Informed Care

http://www.samhsa.gov/nctic/

National Child Traumatic Stress Network
www.nctsn.org

The Sanctuary Model
http://www.sanctuaryweb.com

Substance Abuse and Mental Health Services Administration
http://www.samhsa.gov

The Trauma Center at the Justice Resource Institute http://www.traumacenter.org/index.php

U.S Department of Housing and Urban Development: Tenant Rights
http://portal.hud.gov/hudportal/HUD?src=/topics/rental_assistance/tenantrights

Helpful Workbooks

Center for Substance Abuse Treatment. *Substance Abuse Treatment: Addressing Specific Needs of Women.* Treatment Improvement Protocol (TIP) Series 51. HHS Publication No. (SMA) 09-4426. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009.

Center for Substance Abuse Treatment. *Substance Abuse Treatment for Persons With Co-Occurring Disorders.* Treatment Improvement Protocol (TIP) Series 42. HHS Publication No. (SMA) 08-392. Rockville, MD. Substance Abuse and Mental Health Services Administration, 2005.

Cohen, J., Mannarino & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents.* New York: The Guildford Press

Courtois, C., & Ford, J. (2013). *Treatment of complex trauma: A sequenced, relationship-based approach.* New York: The Guildford Press.

Dishion, T., Stormshak, E., & Kavanagh, K. (2012). *Everyday parenting: A professional guide to building family management skills.* Champaign, IL: Research Press Publishers.

Harris, M. (1998). *Trauma recovery and empowerment: A clinician guide for working with women in groups.* New York: The Free Press.

Harris, M. (2001). *Non-traditional parenting interventions: The impact of early trauma on parenting roles.* Retrieved from Community Connection Website at: http://www.communityconnectionsdc.org/web/page/617/interior.html

Linehan, Marsha. (1993). *Skills training manual for treating borderline personality disorder.* New York: The Guildford Press.

Najavitis, Lisa. *Seeking safety: A treatment manual for PTSD and substance abuse.* New York: The Guildford Press.

Substance Abuse and Mental Health Services Administration. *Comprehensive Case Management for Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series, No. 27/ HHS Publication No. SMA 12-4215. Rockville, MD: Author. 2012. Retrieved from: ttp://store.samhsa.gov/product/TIP-27-Comprehensive-Case-Management-for-Substance-Abuse-Treatment/SMA12 -4215

Assessment Tools

Secondary Traumatic Stress Scale

Scoring
The scoring for the tool for the Secondary Traumatic Stress Scale is as follows.

- A total score at or below 28 = Little or no secondary traumatic stress
- A total score of 28-37 = Mild secondary stress
- A total score of 38-43 = Moderate secondary traumatic stress
- A total score of 44-48= high secondary stress
- A total score of 49 and above= Severe secondary traumatic stress

The score ratings can provide guidance about what self-care steps are needed. Generally, a score of 38 or above will indicate that active steps will need to taken to address the stressors.

Available with permission from the author:

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Phone: (706) 542-5425

Bride, B., Robinson, M. Yegidis. B. & Figley, C. (2004). Development and validation of the Secondary Traumatic Stress Scale. *Research and Social Work Practice,* 14, 27-35.

Life Events Checklist

Scoring

The Life-Event Checklist is a self-report measure that is designed to screen for exposure to traumatic events over a lifetime. It is not intended to diagnose but to understand the scope of experienced stressful events. Therefore, scoring is not necessary. One can assign a score of 1 to items that that the respondent has endorsed and sum the total score.

Available from the United States Departments of Veterans Affairs at the National Center for PTSD website: www.ptsd.va.gov

Gray, M. J., Litz, B. T., Hsu, J. L. & Lombardo, T. W. (2004). *The psychometric properties of the Life Events Checklist.* Assessment, 11, 330-341

Life Stressor Checklist

Scoring

The Life Stressor Checklist is a self-report measure that is designed to screen for trauma over a lifetime in specific domains. It is not intended to diagnose but to understand the range of stressful events an individual has experienced. Therefore scoring is not necessary.

Available from the United States Departments of Veterans Affairs at the National Center for PTSD website: www.ptsd.va.gov

Wolfe, J., & Kimerling, R. (1997). Gender issues in the assessment of Posttraumatic Stress Disorder. In J. Wilson & T.M. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 192-238). New York: Guilford.

The Managed Health Care Organizational Readiness Checklist
Scoring
The total score for each domain can range from 1 to 5, with 1 as weakest position and 5 as the strongest. For scoring on the Adult Services Comprehensiveness domain, individual response scores are added together in that section and divided by 6 to get a composite score. For Service Characteristics, individual response scores are added and divided by 12 to get the composite score. The composite score demonstrates the strength and weakness of the agency relating to the domain.

Available from the Substance Abuse and Mental Health Service Administration (SAMHSA) treatment improvement protocol series publications, series 27.

Substance Abuse and Mental Health Services Administration. *Comprehensive Case Management for Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series, No. 27/ HHS Publication No. SMA 12-4215. Rockville, MD: Author. 2012. Retrieved from: ttp://store.samhsa.gov/product/TIP-27- Comprehensive-Case-Management-for-Substance-Abuse-Treatment/SMA12 -4215

Simple Screening Instrument for Substance Abuse
Scoring
Although, it is a 16-item scale, only 14 items are scored. A score of 4 or greater reveals moderate or high level of risk for substance abuse, indicating the cut-off point for a referral for full assessment for services to a drug and alcohol treatment provider.

Available from the Substance Abuse and Mental Health Service Administration (SAMHSA) treatment improvement protocol series publications, series, and 42.

Center for Substance Abuse Treatment. *Substance Abuse Treatment for Persons With Co-Occurring Disorders.* Treatment Improvement Protocol (TIP) Series 42. HHS Publication No. (SMA) 08-392. Rockville, MD. Substance Abuse and Mental Health Services Administration, 2005.

Drug Abuse Screening Test
Scoring
It is a 28-item instrument with yes or no responses. A cutoff score 6 has been found to indicate an individual as having substance use disorder. A score over 12 indicates a serious substance abuse problem. Scoring instructions are available with the instrument.
Available from the Centre for Addiction and Mental Health at www.camh.net.

University of Rode Island Change Assessment Scale (URICA)
The instrument can assesses for the 4 subgroups associated with the stages of change. A total cut of score can also assess for total level of readiness associated with the stage of change. The cut off scores and corresponding stage of change are below

- 8 or lower classified as Pre-contemplators
- 8-11 classified as Contemplators
- 11-14 classified as Preparers into Action Takers

Available at University of Maryland at *www.umbc.edu*

McConnaughy, E. A., Prochaska, J. O., & Velicer, W. F. (1983). Stages of change in psychotherapy: Measurement and sample profiles. *Psychotherapy: Theory, Research, and Practice*, 20, 368-375

Danger Assessment Scale
A total score for the yes answers helps identify the level of danger. The total scores indicate the following:

- 0-7, variable danger,
- 9-13, increased danger
- 14-17, severe danger
- 18 and above, extreme danger.

Available at www.dangerassessment.org

Campbell, J, Webster, D & Glass, N(2009). The danger assessment: validation of a lethality risk assessment instrument for intimate partner femicide. *Journal of Interpersonal Violence*, 24(4653-674).

Impact of Life Scale
Scoring: There is no cut off score for this scale. There are three domains that this tool assesses. The mean of the sub-score indicates the presence of the associated symptoms. Scoring information accompanies the tool.

Available from permission from developer Daniel S. Weiss, Ph.D., at:

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Weiss, D. S**.** (2004). The Impact of Event Scale-Revised. In J. P. Wilson, & T. M. Keane (Eds.), *Assessing psychological trauma and PTSD: A practitioner's handbook* (2nd ed., pp. 168-189). New York: Guilford Press.